STATE OF MICHIGAN

IN THE SUPREME COURT

DRAGO KOSTADINOVSKI and
BLAGA KOSTADINOVSKI,
as Husband and Wife,

Plaintiffs-Appellees,

v.

STEVEN D. HARRINGTON, M.D. and
ADVANCED CARDIOTHORACIC
SURGEONS, P.L.L.C.,

Defendants-Appellants.

Supreme Court No.
Court of Appeals No. 333034

Macomb County Circuit Court
No. 14-2247-NH
Hon. Kathryn A. Viviano

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Notice of Filing Supreme Court Application for Leave to Appeal

Michigan Supreme Court Docket No. _____
Michigan Court of Appeals No. 333034
Macomb County Circuit Court No. 14-2247-NH

PLEASE TAKE NOTICE that Defendants Steven D. Harrington, M.D. and Advanced Cardiothoracic Surgeons, P.L.L.C. have filed an Application for Leave to Appeal to the Michigan Supreme Court in the above-referenced matter.

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Dated: December 5, 2017

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DEFENDANTS-APPELLANTS STEVEN D. HARRINGTON, M.D. AND ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.'S APPLICATION FOR LEAVE TO APPEAL

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Order Appealed From and Jurisdictional Statement

On May 19, 2016, plaintiffs-appellees Drago and Blaga Kostadinovski's filed a timely claim of appeal from the trial court's April 29, 2016 final Opinion and Order denying their motion to amend their complaint. See MCR 7.205(A).[1] On October 24, 2017, the Court of Appeals (Judges Murphy, Borrello, and Ronayne Krause) issued a published opinion reversing the trial court and remanding for further proceedings consistent with its opinion.[2]

Under MCL 600.215, MCR 7.303(B)(1), and MCR 7.305(H)(1), this Court may grant leave to appeal or order other relief after a decision of the Court of Appeals. Under MCR 7.305(C)(2), this application for leave to appeal is timely because it is being filed within forty-two days of the Court of Appeals' October 24 opinion.

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[1] **Exhibit 1**, Opinion and Order, dated Apr. 29, 2016. On June 8, 2016, defendants-appellants Steven D. Harrington, M.D. and Advanced Cardiothoracic Surgeons, P.L.L.C. timely filed a protective cross-appeal. The cross-appeal wasn't necessary for the Court of Appeals to reach the alternative basis to affirm that Dr. Harrington and Advanced Cardiothoracic Surgeons raised in their appeal brief. See Defendants Brief on Appeal, p. 21.

[2] **Exhibit 2**, Court of Appeals Opinion.

Statement of Questions Presented

Issue I

Kostadinovski didn't ask to amend his NOI in the trial court. He didn't raise MCL 600.2301 in the trial court. Yet the Court of Appeals held that the trial court abused its discretion because it didn't consider whether Kostadinovski can amend his NOI under MCL 600.2301. Did the trial court abuse its discretion in denying Kostadinovski's motion for leave to amend his *complaint* based on relief and a statute that he didn't raise?

Plaintiffs-appellants answer, "yes."

Defendants-appellees answer, "no."

The trial court did not address this issue because it was raised for the first time on appeal.

The Court of Appeals answered, "yes," though it did not address the fact that Kostadinovski didn't ask to amend his NOI or rely on MCL 600.2301 in the trial court.

Issue II

After the claims in Kostadinovski's NOI and complaint proved meritless, he wanted to raise an entirely new theory. He could have sent a new NOI. But he didn't. Can plaintiffs avoid a defendant's statutory right to pre-suit notice by amending their NOI under MCL 600.2301 to include an entirely new theory?

Plaintiffs-appellants answer, "yes."

Defendants-appellees answer, "no."

The trial court did not address this issue because it was raised for the first time on appeal.

The Court of Appeals answered, "yes," stating that MCL 600.2301 was "implicated and potentially applicable" when "discovery has shed new light on the case and given rise to a new liability theory."

Introduction: Reasons this Court should peremptorily reverse or, in the alternative, grant leave to appeal.

The Court of Appeals held that the trial court abused its discretion because it failed to consider awarding relief that plaintiffs didn't request under a statute that they didn't cite. That wouldn't merit reversal under de novo review. Yet the Court of Appeals, without acknowledging plaintiffs' failure to raise the argument in the trial court, reversed under an abuse-of-discretion standard. Simply put, trial courts do not err or abuse their discretion when they don't consider arguments that the litigants never raised. The Court of Appeals clearly erred in holding otherwise and should be reversed.

This is a medical-malpractice action in which, after nearly two years of discovery, plaintiffs Drago and Blaga Kostadinovski's experts admitted that the theories of liability in their notice of intent to sue (NOI) and complaint were meritless. Kostadinovski[3] stipulated to summary disposition on his pleaded claims, but moved to amend his complaint to add an entirely new theory. He didn't ask the trial court for leave to amend his NOI. And he didn't serve a new NOI. The trial court denied Kostadinovski's motion for leave to amend his complaint, holding that the amendment would be futile because the new theory wasn't in an NOI. Published Court of Appeals case law supported the trial court's analysis.

On appeal, Kostadinovski argued that he didn't need to include the new theory in an NOI. His position was, essentially, that giving notice of one claim pre-suit, gives notice of all claims. The Court of Appeals rejected that argument because it would

[3] Blaga Kostadinovski's loss of consortium claim is derivative of her husband's claims. So, for simplicity, this brief refers to Drago Kostadinovski as "Kostadinovski."

"undermine the legislative intent and purpose behind" the NOI requirement. Yet the Court of Appeals reversed and directed the trial court "to engage in an analysis under MCL 600.2301 to determine whether amendment of the NOI or disregard of the prospective NOI defect would be appropriate."

The trial court didn't "engage in an analysis under MCL 600.2301" because Kostadinovski didn't ask it to. It didn't consider "whether amendment of the NOI or disregard of the prospective NOI defect would be appropriate" because Kostadinovski didn't argue that it was. Trial courts don't err, much less abuse their discretion, when they don't consider authority or arguments that the parties didn't raise. The panel lost sight of two fundamentals of appellate review: (1) issue preservation, and (2) the standard of review. As a result, it clearly erred and this Court should peremptorily reverse.

In addition, if left intact, the Court of Appeals' published opinion has potentially far-reaching consequences. Though it left initial review to the trial court, the panel stated that MCL 600.2301 "must … be implicated and potentially applicable" and the circumstances for amendment were "even more compelling" when plaintiffs raise an entirely new theory after their original theories are proven meritless. That's wrong.

Nothing in Kostadinovski's NOI even hinted at his new theory. So if amendment is allowed under the statute, defendants would be forced to litigate a theory without receiving any pre-suit notice or opportunity to review it. As the panel stated when rejecting Kostadinovski's argument, that would "undermine the legislative intent and purpose behind" the NOI requirement. Defendants would be deprived their statutory

right to consider and address the claim outside the context of litigation. So the statute cannot apply and cannot allow an amendment to add an entirely new claim.

Kostadinovski should have done what the NOI statute required—send an NOI for his new theory. For unknown reasons, he didn't do that. He shouldn't be excused from the statutory requirement simply because he gave notice of other, meritless claims. The Court of Appeals erred in suggesting that Kostadinovski's failure to send an NOI for his new claim could be cured through amendment. Again, this Court should reverse.

Counterstatement of Facts

A. Kostadinovski served an NOI and filed a complaint alleging medical-malpractice theories that his experts couldn't support.

In December 2011, Dr. Harrington performed a minimally invasive surgery rather than open-heart surgery on Kostadinovski's mitral valve.[4] Dr. Harrington performed the surgery with the assistance of a da Vinci robot and used an EndoClamp.[5] Kostadinovski suffered a stroke after the surgery.[6]

In December 2013, Kostadinovski served a notice of intent to sue (NOI).[7] The NOI claimed that Dr. Harrington's pre-surgical assessment breached the standard of care because he didn't perform a "thorough history and physical" and didn't order certain diagnostic studies:

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[4] **Exhibit 3**, Complaint, ¶¶35-36.

[5] Ex. 3, *Id.*, ¶¶35-36, 41-42.

[6] Ex. 3, *Id.*, ¶53.

[7] **Exhibit 4**, NOI.

(1) On December 9, 2011, and continuously thereafter, Dr. Harrington failed to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

(2) On December 9, 2011, and continuously thereafter, Dr. Harrington failed to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski[.[8]]

The NOI further claimed that Dr. Harrington should have discovered a clot in Kostadinovski's arterial tree before the surgery, which, he alleged, should have led Dr. Harrington to determine that he couldn't use an EndoClamp during the surgery:

(3) On December 9, 2011 and December 14, 2011 and continuously thereafter, Dr. Harrington failed to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

(4) On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington failed to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

(5) On December 14, 2011 and continuously thereafter, Dr. Harrington failed to immediately abort the DaVinci mitral

[8] Ex. 4, NOI, p. 10.

> valve repair due to the presence of thrombus, clot or calcium within the arterial tree;
>
> (6) On December 14, 2011 and continuously thereafter, Dr. Harrington failed to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair[.[9]]

Kostadinovski's causation theory was that the EndoClamp "disrupt[ed]" or "broke[] loose" a clot in his arterial tree that moved to Kostadinovski's brain, causing his stroke.[10]

After waiting the applicable notice period, Kostadinovski filed a complaint with an affidavit of merit. The alleged breaches of the standard of care and theory of causation in the complaint and the affidavit of merit were identical to the NOI.[11] Kostadinovski's wife alleged a derivative loss-of-consortium claim.[12]

After a year-and-a-half of discovery, Kostadinovski's experts didn't support his medical-malpractice theory. Dr. Edgar Chedreawy, who signed the affidavit of merit, testified that the standard of care didn't require Dr. Harrington to obtain the pre-operative diagnostic studies alleged in Kostadinovski's complaint before using an EndoClamp:

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[9] Ex. 4, NOI, pp. 10-11.

[10] Ex. 4, NOI, pp. 13-14; see also ex. 1, Complaint, ¶¶75-77.

[11] Ex. 4, NOI, pp. 10-11; Ex. 3, Complaint, ¶70; Affidavit of Merit of Edgar Chedrawy, M.D., ¶10.

[12] Ex. 3, Complaint, ¶¶81-82.

> Q. Do you believe that the standard of care, meaning the average, reasonable, prudent cardiothoracic surgeon -- not the best, not the wors[t], somebody who's just reasonable and prudent -- was required or also does CT angiograms to formally evaluate the aorta?
>
> A. I guess now I understand your question a little better. I guess to clarify, in 2011, that may not have been considered the standard of care. But nowadays, I believe it would be the standard of care. Yes.
>
> * * *
>
> Q. So -- and just so if I can paraphrase, and you tell me if I'm wrong, it's your opinion that while now you believe that the standard of care formally does require a CT angiogram to evaluate the aorta prior to utilizing an EndoClamp; in 2011, you're not -- **you don't believe you can say that the standard of care required Dr. Harrington to do a preoperative CT angiogram; is that fair**?
>
> A. **That is fair**.[13]

Kostadinovski's other standard-of-care expert, Dr. Louis Samuels, confirmed that the conduct alleged in the complaint didn't violate the standard of care:

> Q. ... In this case, Doctor, what -- let's put CT angiography out of it for a minute. Other than CT angiography, do you have an opinion that Dr. Harrington violated the standard of care in his preoperative assessment of the aorta?
>
> A. No.
>
> Q. So, the only test that you suggest that -- and I'm going to use specific terms, so listen to me. The only thing that you suggest that he should have done, and I'm saying you, not the standard of care, is that you think because CT angiography was around and based on what you reviewed, you think it would have been a good tool to utilize in this case, correct?

[13] **Exhibit 5**, Chedrawy Dep, pp. 28-29 (emphasis added).

A. Yes.

Q. But **you are not sitting here telling me that he violated the standard of care with respect to his preoperative assessment of the aorta, correct**?

A. **That is fair**.[14]

And Kostadinovski's causation expert, Dr. Thomas Naidich (a neuroradiologist), testified that he didn't see any evidence of a clot (emboli) in the imaging studies of Kostadinovski's brain:

A. … **I have no specific evidence here for emboli, period**. I have no evidence for emboli.

* * *

A. And I would like to add so it's clear, I'm trying to be very careful. **I see nothing that is absolutely embolic**.

* * *

A. Everybody is saying that it could be embolic and while that's possible **there isn't any evidence on the imaging studies for emboli**.[15]

B. Kostadinovski stipulated to summary disposition on his pleaded claims, but moved to amend his complaint to add a claim that he never put in an NOI.

Dr. Harrington and Advanced Cardiothoracic moved for summary disposition and to preclude Kostadinovski from pursuing new theories. Kostadinovski stipulated to an order dismissing the "allegations of negligence and theory of causation as pled in

[14] **Exhibit 6**, Samuels Dep, pp. 45-46 (emphasis added).

[15] **Exhibit 7**, Naidich Dep., pp. 36-37, 42-43.

[his] Notice of Intent, Complaint and Affidavit of Merit" with prejudice.[16] But he moved to amend his complaint to raise a new theory.

Kostadinovski's new theory alleged that Dr. Harrington breached the standard of care by "fail[ing] to appreciate Mr. Kostadinovski's hypotensive [low blood pressure] status and transfuse the patient" during surgery.[17] The new causation theory was that the low blood pressure led to "inadequate supply of oxygen and nutrients" to Kostadinovski's brain, which caused his stroke.[18]

There was no dispute that Kostadinovski's NOI and original complaint didn't say anything about monitoring his hypotensive status or transfusing him during surgery. The parties' arguments focused on whether the amendment was futile and whether Kostadinovski unduly delayed seeking the amendment.

C. The trial court denied leave to amend the complaint because it was futile to add a new claim that Kostadinovski never put in an NOI.

The trial court issued a written opinion.[19] Though it concluded that an amendment of the complaint would relate back to the original filing,[20] the court held that the amendment was futile because Kostadinovski didn't comply with the NOI requirements for the new theory:

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[16] Order, dated April 25, 2016.

[17] **Exhibit 8**, Proposed Amended Complaint, ¶¶45-46, 71(g)-(h), 72(g)-(h).

[18] Ex. 8, Proposed Amended Complaint, ¶80; Ex. 7, Naidich Dep., pp. 30-31, 34 ("There is infarcted [dead tissue] because there was inadequate supply of oxygen and nutrients.").

[19] Ex. 1, Opinion and Order, dated Apr. 29, 2016

[20] Ex. 1, Opinion and Order, pp. 3-6, relying on *Doyle v Hutzel Hosp*, 241 Mich App 206; 615 NW2d 759 (2000).

> The Court finds that plaintiffs' NOI did not set forth the minimal requirements to provide notice of the claim of breach of the standard of care with regard to the failure to monitor hypotension levels during the operation and the failure to transfuse the patient was a potential cause of injury as required by MCL 600.2912b. Accordingly, defendants were not given the opportunity to engage in any type of settlement negotiation with regard to the hypotension and transfusion claims because they were not given notice of the existence of any such claims. Even if plaintiffs had included these new allegations in their original complaint, defendants lacked the requisite notice mandated by MCL 600.2912b because they were not raised in the NOI.[21]

Since the futility analysis was dispositive, the court didn't address the undue-delay argument.

D. The Court of Appeals reversed based on relief that Kostadinovski didn't request and under a statute that he didn't cite in the trial court.

Kostadinovski appealed, arguing that the amendment wasn't futile because the NOI statute doesn't apply to amended complaints. Dr. Harrington and Advanced Cardiothoracic's appeal brief explained that Kostadinovski's argument didn't reconcile with the text and purpose of the NOI statute, nor the case law applying it.

The Court of Appeals agreed with defendants. It rejected Kostadinovski's argument, explaining that it wasn't supported by Michigan law and conflicted with the purpose of the NOI requirement:

> Plaintiffs argue that MCL 600.2912b simply requires the service of an NOI before suit is filed and that once this is accomplished through the service of a proper and compliant NOI, as judged at the time suit is filed and by the language in the original complaint, the requirements of the statute have been satisfied, absent the need to revisit the NOI even if a new theory of

[21] Ex. 1, Opinion and Order, dated Apr. 29, 2016, pp. 8-9.

> negligence or causation is later developed that was not included in the NOI and that forms the basis of an amended complaint. If this were the law, the entire analysis in *Decker* would have been completely unnecessary, because a proper and compliant NOI had been served on the defendants, as judged on the date the original complaint was filed and by the language in that complaint. Moreover, the approach suggested by plaintiffs would undermine the legislative intent and purpose behind MCL 600.2912b.[22]

But the panel reversed based on Kostadinovski's alternative argument. Kostadinovski argued that he should have been allowed to amend his complaint based on MCL 600.2301 and this Court's decision in *Bush v Shabahang*, 484 Mich 156; 772 NW2d 272 (2009).[23] Dr. Harrington and Advanced Cardiothoracic explained that Kostadinovski waived the issue because he didn't ask to amend his NOI in the trial court and never cited MCL 600.2301 or *Bush*.[24] They added that, unlike *Bush* where the plaintiff tried but failed to adequately describe the claim, Kostadinovski never tried to describe his new theory in an NOI.[25] So, even if Kostadinovski had properly raised the issue in the trial court (he didn't), it would be meritless.

The panel said nothing about Kostadinovski's failure to raise the issue in the trial court. It framed the issue as whether *Bush*'s analysis of MCL 600.2301 "governs" the "procedural circumstances" in this case.[26] The panel held that "*Bush* controls our

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[22] Ex. 2, Court of Appeals Opinion, p. 9 n.6 (emphasis added).

[23] Kostadinovski Court of Appeals Brief, pp. 20-23.

[24] Defendants Court of Appeals Brief, pp. 18-19.

[25] *Id.* at 19-20.

[26] Ex. 2, Court of Appeals Opinion, p. 6.

analysis."[27] It added that the "factual circumstances are even more compelling for the invocation of MCL 600.2301" when, unlike *Bush*, the plaintiff completely omits any mention of a new theory in an NOI:

> If MCL 600.2301 is implicated and potentially applicable to save a medical malpractice action when an NOI is defective because of a failure to include negligence or causation theories required by MCL 600.2912b(4), then, by analogy, MCL 600.2301 must likewise be implicated and potentially applicable when an NOI is deemed defective because it no longer includes the negligence or causation theories required by MCL 600.2912b(4) and alleged in the complaint, due to a post-complaint change in the theories being advanced by a plaintiff as a result of information gleaned from discovery. There is no sound or valid reason that the principles from *Bush* should not be applied here. Indeed, as a general observation, factual circumstances are even more compelling for the invocation of MCL 600.2301 when an NOI is not defective from the outset but becomes defective because discovery has shed new light on the case and given rise to a new liability theory.[28]

Though the panel acknowledged that it "reviews for an abuse of discretion a trial court's ruling on a motion for leave to amend,"[29] it reversed, directing the trial court to consider a statute and relief that Kostadinovski never asked it to before.

Standard of Review

A trial court's ruling on a motion to amend a complaint is reviewed for an abuse of discretion. *Weymers v Khera,* 454 Mich 639, 654; 563 NW2d 647 (1997). Trial courts

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[27] Ex. 2, Court of Appeals Opinion, p. 8.

[28] Ex. 2, Court of Appeals Opinion, p. 8 (emphasis added).

[29] Ex. 2, Court of Appeals Opinion, p. 3, citing *Franchino v Franchino*, 263 Mich App 172, 189; 687 NW2d 620 (2004).

don't abuse their discretion unless their "decision falls outside this range of principled outcomes." *Pontiac Fire Fighters Union Local 376 v Pontiac*, 482 Mich 1, 8; 753 NW2d 595 (2008).

The Michigan Court Rules provide that "[l]eave to amend shall be freely given when justice so requires." MCR 2.118(A)(2). But, despite that general rule, leave to amend is properly denied for: "[1] undue delay, [2] bad faith or dilatory motive on the part of the movant, [3] repeated failure to cure deficiencies by amendments previously allowed, [4] undue prejudice to the opposing party by virtue of allowance of the amendment, [and 5] futility." *Weymers*, 454 Mich at 658.

Argument I

The trial court didn't abuse its discretion. Kostadinovski didn't ask it to amend his NOI under MCL 600.2301. And the trial court wasn't required to raise and consider that issue on its own. The Court of Appeals clearly erred in reversing the trial court based on an issue that Kostadinovski waived.

"Trial courts are not the research assistants of the litigants; the parties have a duty to fully present their legal arguments to the court for its resolution of their dispute." *Walters v Nadell*, 481 Mich 377, 388; 751 NW2d 431 (2008). The Court of Appeals reversed because the trial court didn't consider an argument and a statute that Kostadinovski never raised in the trial court. The trial court had no obligation to raise the issue on its own. And it certainly didn't abuse its discretion by not doing so.

A. Michigan's raise-or-waive rule promotes judicial efficiency and prevents litigants from avoiding their unsuccessful tactical decisions.

This Court's decision in *Walters*, which Dr. Harrington and Advanced Cardiothoracic relied on in the Court of Appeals,[30] is controlling. In *Walters*, the plaintiff had difficulty serving the defendant, who was in the military. *Id.* at 380. After he was finally served, the defendant moved for summary disposition based on the statute of limitations. *Id.* at 380-381. The plaintiff's response didn't raise a federal statute that tolled the limitation period during the defendant's military service. *Id.* at 379, 381. The trial court granted summary disposition. On appeal, the plaintiff argued, for the first time, that the federal tolling provision required reversal. *Id.* at 381. The Court of Appeals affirmed, holding that the federal tolling provision was unpreserved and discretionary. *Id.* This Court affirmed based exclusively on waiver. It held that the tolling provision was mandatory, but the plaintiff waived it by failing to raise it in response to the summary-disposition motion:

> It is undisputed that plaintiff did not raise the tolling provision of the SCRA in response to defendant's motion. Thus, under our "raise or waive" rule, it is undisputed that the plaintiff waived the tolling provision. [*Id.* at 389.]

Walters explained that Michigan's raise-or-waive rule is "based in the nature of the adversarial process and judicial efficiency." *Id.* at 388. It "require[s] litigants to raise and frame their arguments at a time when their opponents may respond to them factually." *Id.* The Court of Appeals' decision in this case illustrates the point.

[30] Defendants Court of Appeals Brief, pp. 18-19.

The panel couldn't decide whether MCL 600.2301 would make a difference. Since Kostadinovski didn't raise it in the trial court, Dr. Harrington and Advanced Cardiothoracic Surgeons didn't have an opportunity to respond to it. The Court of Appeals solution, requiring the trial court to address the issue on remand, smacks of inefficiency. *Napier v Jacobs*, 429 Mich 222, 228-229; 414 NW2d 862 (1987) ("'[I]f an issue had been raised in the trial court, it could have been resolved there, and the parties and public would be spared the expense of an appeal.'"), quoting 3 LaFave & Israel, Criminal Procedure, § 26.5(c), pp. 251-252.

The trial court did nothing wrong, yet the Court of Appeals held that it must make room in its docket at the expense of other cases for a do-over. And the do-over won't stop there. The panel acknowledged that the trial court's ruling would be "subject of course to appeal on the § 2301 analysis."[31] So, under the panel's decision ignoring *Walters* and the raise-or-waiver rule, inefficiency prevails. The parties and public will be subjected to the expense of bouncing between courts on an issue that Kostadinovski could have raised the first time around, but didn't—which leads to the next point.

The raise-or-waive rule "avoids the untenable result of permitting an unsuccessful litigant to prevail by avoiding its tactical decisions that proved unsuccessful." *Walters*, 481 Mich at 388. Kostadinovski elected not to serve a new NOI when he learned of the new theory eight months before he moved to amend his

[31] Ex. 2, Court of Appeals Opinion, p. 10.

complaint.[32] Instead, he took an aggressive position. He argued that he didn't need to serve a new NOI and could amend any claim into his complaint, unencumbered by the NOI requirement. The trial court and the Court of Appeals rejected that argument.

Kostadinovski made a tactical decision. It proved unsuccessful. As *Walters* put it, the Court of Appeals' opinion permitting Kostadinovski to avoid his unsuccessful tactical decision is untenable. *Id.* Indeed, "'there is something unseemly about telling a lower court it was wrong when it never was presented with the opportunity to be right.'" *Napier*, 429 Mich 228-229, quoting 3 LaFave & Israel, Criminal Procedure, § 26.5(c), pp. 251-252; see also *Hunter v Cilluffo*, unpublished opinion per curiam of the Court of Appeals, issued May 24, 2016 (Docket No. 326088); 2016 WL 3004566 (**Exhibit 9**) (affirming dismissal when the "[p]laintiff did not ... request an opportunity to amend his NOI in lieu of dismissal, or argue that an amendment would be 'in the furtherance of justice'").

A distinction between *Walters* and this case underscores the Court of Appeals' error. In *Walters*, the trial court's summary-disposition ruling was subject to de novo review. *Id.* at 381. Here, the trial court's ruling on Kostadinovski's motion to amend his complaint is subject to abuse-of-discretion review. *Weymers,* 454 Mich at 654. The panel's reversal based on a statute that wasn't raised in the trial court under an abuse-of-discretion standard is irreconcilable with *Walters*'s holding that a mandatory tolling provision was waived under de novo review.

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[32] Mar. 28, 2016 Hrg. Tr., p. 8 (Kostadinovski's attorney admitting that he knew about the claim as early as July 2015); Plaintiff's Motion to Amend Complaint (filed March 21, 2016).

B. The "miscarriage of justice" exception to the raise-or-waive rule couldn't possibly apply in this case.

This Court has acknowledged that appellate courts may "review an issue not raised in the trial court to prevent a miscarriage of justice …." *Walters*, 481 Mich at 387. But it has also instructed that "such power of review is to be exercised quite sparingly." *Napier*, 429 Mich at 233. More than loss of a money judgment in a civil case is needed to show a miscarriage of justice. *Id.* Otherwise, the exception would consume the rule and courts would have to sua sponte review every issue in a civil case, regardless whether it was properly and timely raised. *Id.* "Such a rule would be in patent conflict with our adversary system of civil justice." *Id.* at 234.

Applying the raise-or-waive rule in this case doesn't implicate a miscarriage of justice. The Court of Appeals didn't address this point. But it's impossible to say that a miscarriage of justice would result from enforcing the waiver rule. The panel couldn't say that Kostadinovski was entitled to relief under MCL 600.2301. Nor could it say that granting relief under MCL 600.2301 would ultimately lead to recovery of a money judgment. So the Court of Appeals couldn't even say that Kostadinovski's waiver would result in the loss of a money judgment, which, again, wouldn't be enough. *Id.* at 233. In short, there is no basis for invoking a miscarriage-of-justice exception to the raise-or-waive rule in this case.

C. The Court of Appeals clearly erred and should be peremptorily reversed because it abandoned its error-correcting function to address an issue that Kostadinovski waived.

The Court of Appeals didn't engage in appellate review. It didn't review the trial court's ruling based on the arguments and materials that were presented to it. See *Kincaid v Cardwell*, 300 Mich App 513, 539; 834 NW2d 122 (2013) ("[T]his Court must determine whether the trial court erred on the basis of the arguments and evidence properly presented to the trial court."). And it didn't consider whether the trial court abused its discretion in how it decided the issue that the parties presented.

Instead, the panel told "a lower court it was wrong when it never was presented with the opportunity to be right." *Napier*, 429 Mich 228-229 (citation omitted). It isn't the Court of Appeals' job to find ways for an "unsuccessful litigant to prevail by avoiding its tactical decisions that proved unsuccessful." *Walters*, 481 Mich at 388. In short, the Court of Appeals failed in its function as an error-correcting court. See *Burns v City of Detroit (On Remand)*, 253 Mich App 608, 615; 660 NW2d 85 (2002)[33] ("[T]he Michigan Court of Appeals 'functions as a court of review that is principally charged with the duty of correcting errors' that occurred below and thus should decline to address unpreserved issues."), quoting *Michigan Up & Out of Poverty Now Coalition v Michigan*, 210 Mich App 162, 167-168; 533 NW2d 339 (1995).

Trial courts do not abuse their discretion when they don't consider arguments that the litigants never raised. See *Duray Dev LLC v Perrin*, 288 Mich App 143, 161; 792

[33] *Burns* was modified on other grounds, see *Burns v City of Detroit*, 468 Mich 881; 658 NW2d 468 (2003).

NW2d 749 (2010) ("Perrin did not raise the issue in the trial court, and the trial court did not err by not raising it for him."). The Court of Appeals clearly erred in reversing the trial court based on the mere possibility of relief that Kostadinovski didn't request under a statute that he didn't cite. Since the Court of Appeals rejected Kostadinovski's argument that NOI statute doesn't apply to amended complaints,[34] this Court should peremptorily reverse and reinstate the trial court's order denying leave to amend the complaint.

Argument II

After the claims in Kostadinovski's NOI and complaint proved meritless, he wanted to raise an entirely new theory. He could have sent a new NOI. But he didn't. Plaintiffs can't avoid a defendant's statutory right to pre-suit notice by amending their NOI under MCL 600.2301 to include an entirely new theory. The Court of Appeals erred when it suggested otherwise.

Though this Court shouldn't need to reach the issue, the Court of Appeals' holding that MCL 600.2301 could, potentially, save Kostadinovski's claim is wrong for a reason familiar to the panel: it would "undermine the legislative intent and purpose behind [the NOI statute]."[35]

This Court has allowed amendment of an NOI under MCL 600.2301 for theories that the NOI at least referenced, albeit insufficiently. But there's no dispute that Kostadinovski's NOI didn't reference his new theory. So there's no dispute that, if amendment of the NOI were allowed, Dr. Harrington and Advanced Cardiothoracic

[34] Ex. 2, Court of Appeals Opinion, p. 9 n.6.

[35] Ex. 2, Court of Appeals Opinion, p. 9 n.6.

would never have any opportunity to review and address the claim outside the context of litigation. They would be completely deprived of their statutory right to an NOI followed by the appropriate notice-waiting period. So amendment under MCL 600.2301 isn't possible for the same reason that the panel rejected Kostadinovski's argument—it would deprive defendants of their statutory right and undermine the legislative purpose of the NOI requirement. Accordingly, if this Court considers the substance of the Court of Appeals' published ruling on this unpreserved issue, it should grant leave to appeal or peremptorily reverse.

A. An amendment is futile when the trial court would be required to grant a summary-disposition motion on the new claim.

The trial court held that Kostadinovski's proposed amended complaint was futile. "'An amendment is futile where, ignoring the substantive merits of the claim, it is legally insufficient on its face.'" *Hakari v Ski Brule, Inc*, 230 Mich App 352, 355; 584 NW2d 345 (1998), quoting *Gonyea v Motor Parts Federal Credit Union*, 192 Mich App 74, 78; 480 NW2d 297 (1991). The trial court was right. If it allowed the amendment, the court would have been required to grant a summary-disposition motion on the new claim because it wasn't included in an NOI.

B. Courts must dismiss new malpractice claims that weren't in an NOI. So the trial court correctly determined that it would have been futile to grant Kostadinovski's motion to amend his complaint to add the new claim.

The NOI statute, MCL 600.2912b, gives potential medical-malpractice defendants a "statutory right to a timely NOI followed by the appropriate notice waiting period." *Tyra v Organ Procurement*, 498 Mich 68, 92; 869 NW2d 213 (2015), quoting *Driver v Naini*,

490 Mich 239, 255; 802 NW2d 311 (2011). It's written in mandatory terms. The NOI must "contain a statement of at least all of the following:

> (a) The factual basis for **the claim**.
>
> (b) The applicable standard of practice or care alleged by the claimant.
>
> (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
>
> (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.
>
> (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.
>
> (f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to **the claim**. [MCL 600.2912b(4) (emphasis added).]"

So the content of the written notice is claim specific. The plaintiff must state the "factual basis for **the claim**" and identify the would-be defendants receiving notice "in relation to **the claim**." MCL 600.2912b(4)(a), (f) (emphasis added). Between those bookends, the statute requires the plaintiff to describe "the applicable standard," how it was breached, and how that breach was "the proximate cause." MCL 600.2912b(4)(b)-(e).

The purpose of the NOI requirement is to promote settlement without the expense of litigation. *Neal v Oakwood Hosp Corp*, 226 Mich App 701, 705; 575 NW2d 68 (1997). But defendants can't consider and settle a claim pre-litigation if they aren't given notice of it. So, to effectuate the NOI statute's purpose, plaintiffs are prohibited from commencing an action on a claim if they didn't give the statutorily required notice of it.

MCL 600.2912b(1); *Boodt v Borgess Med Ctr*, 481 Mich 558, 562-563; 751 NW2d 44 (2008) ("[A] plaintiff cannot commence an action before he or she files a notice of intent that contains all the information required under § 2912b(4).").

Kostadinovski proposed an end-run around the NOI requirement. Notice of one claim is notice of all claims, he argued. But, as the Court of Appeals acknowledged, that can't be. It would subvert the NOI requirement, undermine its purpose (would-be defendants can't assess and settle pre-suit what isn't in a notice), and deny defendants their statutory right to pre-suit notice. Two published Court of Appeals cases settled the point. *Gulley-Reaves v Baciewicz*, 260 Mich App 478; 679 NW2d 98 (2004); *Decker v Rochowiak*, 287 Mich App 666; 791 NW2d 507 (2010).

In *Gulley-Reaves*, the plaintiff served an NOI on a hospital alleging that it was vicariously liable for a surgeon and residents. But her complaint added different claim, alleging that the hospital was vicariously liable for an anesthesiologist and nurse anesthetist. The hospital moved for partial summary disposition, arguing that the NOI deficiently described the anesthesia claims. The trial court denied the motion. But the Court of Appeals agreed that the NOI was deficient and ordered summary disposition for the hospital. The Court held that "the complaint must be limited to the issues raised in the notice of intent ...." 260 Mich App at 485. The plaintiff could have served an additional notice of intent to add the new claims. *Id.* at 486, citing MCL 600.2912b(6). But she didn't. So she "failed to provide notice of the claim of breach of the standard of care with regard to administration of anesthesia" and "the trial court erred in denying defendants' motion for summary disposition." *Id.* at 490.

Below, Kostadinovski argued that *Gulley-Reaves* didn't apply because it didn't involve a proposed amendment to a complaint. But *Decker* did.

In *Decker*, the plaintiff served several defendants with an NOI. After filing his complaint and conducting some discovery, the plaintiff moved to amend his complaint. He argued that the amendment "merely clarified allegations and issues." 287 Mich App at 671. The trial court and the Court of Appeals agreed and allowed the amendment. The Court of Appeals repeatedly stated that *Gulley-Reaves* didn't apply because the amendments didn't raise a new potential cause of the injury:

- "Contrary to the Spectrum defendants' argument, plaintiff's subsequently filed **amended complaint did not assert any 'new' potential causes of injury**." *Id.* at 678 (emphasis added).
- "[T]he allegations in plaintiff's amended complaint **merely set forth more specific details, clarifying plaintiff's claims** against the Spectrum defendants, including the registered nurses and physicians involved in Eric's medical management." *Id.* (emphasis added).
- "Unlike the plaintiff in *Gulley-Reaves*, plaintiff's amended complaint **did not allege any other potential cause of Eric's injury**." *Id.* at 680 (emphasis added).
- "**This is not a case where, as in *Gulley-Reaves*, the plaintiff set forth a totally new and different potential cause** of injury in an amended complaint compared to the potential cause of injury set forth in her NOI …." *Id.* (emphasis added).
- The Court rejected the defendants' argument that the plaintiff had to wait out a new NOI period because, "The amended complaint did not name new defendant parties, MCL 600.2912b(3), and **it did not set forth any new potential causes of injury**." *Id.* at 681 (emphasis added).

So *Decker* allowed the amendment only because it did not assert a new potential cause. Yet Kostadinovski argued that *Decker* allowed him to include any new theory in

an amended complaint. He tried cherry-picking a quote from *Decker* out of context to support his argument. *Decker* stated, "Plaintiff was not required to file a second NOI with regard to these defendants after he was granted leave to file his amended complaint, **a complaint that merely clarified plaintiff's claims against the Spectrum defendants**." 287 Mich App at 681 (emphasis added). Kostadinovski's argument ignored the emphasized text—in addition to the rest of *Decker*'s analysis.

As the Court of Appeals explained, "[i]f [Kostadinovski's argument] were the law, the entire analysis in *Decker* would have been completely unnecessary …."[36] In other words, if Kostadinovski was right, *Decker*'s entire analysis comparing the original and amended complaints was pointless. But *Decker* made the comparison, at length, because it was necessary to distinguish *Gulley-Reaves*. The panel in this case correctly rejected Kostadinovski's argument because it conflicted with established Michigan law and the purpose of the NOI statute.

So, as the trial court concluded, Kostadinovski's amendment was futile under *Gulley-Reaves*. Because "the complaint must be limited to the issues raised in the notice of intent" and Kostadinovski's new theory "set forth [a] new potential causes of injury,"[37] his proposed amendment was futile and the trial court didn't abuse its

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[36] Ex. 2, Court of Appeals Opinion, p. 9 n.6. Kostadinovski's argument would also make the entire analysis in *Bush* completely unnecessary. *Bush* discussed amending an NOI that defectively described some claims, but not others. But if giving sufficient notice of one claim allows plaintiffs to add any other theory through an amended complaint, *Bush*'s entire discussion would be moot.

[37] There's no dispute on this point. The original causation theory was that the EndoClamp caused a clot to break loose and move to Kostadinovski's brain. See ex. 3, Complaint, ¶¶75-77. The new theory is that low blood pressure caused an "in adequate

discretion in denying leave to amend. *Gulley-Reaves*, 260 Mich App at 485; *Decker*, 287 Mich App at 681. But the Court of Appeals thought (incorrectly) that it found a potential way to avoid that result.

C. MCL 600.2301 cannot allow plaintiffs to "amend" an NOI to include an entirely new theory.

The Court of Appeals held that, "by analogy" to this Court's decision in *Bush*, "MCL 600.2301 is implicated and potentially applicable to save [Kostadinovski's] medical malpractice action …."[38] It's wrong. Under *Bush*, MCL 600.2301 only applies when (1) the amendment wouldn't affect a party's substantial rights, and (2) the plaintiff made a good-faith attempt to comply with the NOI requirements. 484 Mich at 177. Neither prong can be met for a claim that wasn't even alluded to in an NOI. The Court of Appeals' published opinion erred in suggesting otherwise.

In *Bush*, "the vast majority of the plaintiff's NOI was in compliance with [the NOI statute]." 484 Mich at 178. It sufficiently described several claims against various defendants. But the NOI also defectively described some claims:

> The notice merely provides that [West Michigan] Cardiovascular should have hired competent staff members and properly trained them.
>
> * * *
>
> Although plaintiff's notice alleges errors on the part of Spectrum Health's nursing staff and physician assistants, the notice does not purport to state a separate standard of care for the nurses and physician assistants.

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supply of oxygen and nutrients" to his brain, which resulted in his stroke. Ex. 7, Naidich Dep., p. 30-31, 34; Ex. 8, Proposed Amended Complaint, ¶80.

[38] Ex. 2, Court of Appeals Opinion, p. 8.

* * *

> Likewise, to the extent that plaintiff purported to give notice that Spectrum Health could be held directly liable for Bush's injuries on the basis of the theories that it negligently hired or failed to train its staff, for the same reasons we explained with regard to [West Michigan] Cardiovascular, we conclude that the notice did not meet the requirements of MCL 600.2912b. [*Bush*, 484 Mich at 179-180, quoting *Bush v Shabahang*, 278 Mich App 703, 711; 753 NW2d 271 (2008).]

So the NOI referred to several claims, but it didn't fully describe them as required by the NOI statute. *Bush*, 484 Mich at 179-180, citing MCL 600.2912b.

Bush considered whether MCL 600.2301 allowed the trial court to "amend" the NOI or "disregard" the defects in it. The statute allows courts to do so "in the furtherance of justice" and when it wouldn't "affect the substantial rights" of a party:

> The court in which any action or proceeding is pending, has power to amend any process, pleading or proceeding in such action or proceeding, either in form or substance, for the furtherance of justice, on such terms as are just, at any time before judgment rendered therein. The court at every stage of the action or proceeding shall disregard any error or defect in the proceedings which do not affect the substantial rights of the parties. [MCL 600.2301.]

Bush held that "the applicability of § 2301 rests on a two-pronged test: first, whether a substantial right of a party is implicated and, second, whether a cure is in the furtherance of justice." *Bush*, 484 Mich at 177. The furtherance-of-justice prong is met "when a party makes a good-faith attempt to comply with the content requirements of §2912b." *Id.* at 178.

In *Bush*, the defendants' substantial rights were not implicated because they had "the ability to understand the nature of the claims being asserted against him or her

even in the presence of defects in the NOI." *Id.* at 178. Amendment was also in the furtherance of justice because the plaintiff "made a good-faith attempt to comply with the content requirements of § 2912b." *Id.* at 161, 180-181.

The NOI in *Bush* referred to the claims, but didn't put any meat on the bones. Here, there are no bones for Kostadinovski's new claim. Kostadinovski's NOI asserts that Dr. Harrington caused a clot to break loose, which led to his stroke. The NOI doesn't refer to hypotension or transfusion during surgery at all. So, unlike the defendants in *Bush*, Dr. Harrington and Advanced Cardiothoracic couldn't have possibly understood "the nature of the claims being asserted against him … even in the presence of defects in the NOI." *Id.* at 178. If amendment were allowed, they would have no opportunity to address the new claim outside the context of litigation. Kostadinovski also made no attempt, much less a good-faith attempt, to comply with the content requirements for his new claim. He could have sent a new NOI. See *Gulley-Reaves*, 260 Mich App at 486, citing MCL 600.2912b(6). But he didn't. Accordingly, Kostadinovski can't amend his NOI under *Bush* and MCL 600.2301.

This isn't a fact-specific issue. The result should be the same any time a plaintiff tries to raise a new theory that wasn't in his NOI. MCL 600.2301 cannot be "potentially applicable"[39] when a claim isn't even alluded to in an NOI. If it were, Dr. Harrington and Advanced Cardiothoracic (and all defendants like them) will **never** get their statutory right to review and address the new claim outside the context of litigation.

[39] Ex. 2, Court of Appeals Opinion, p. 8.

Since *Bush*, this Court has confirmed that the NOI requirement isn't a mere formality that can be lightly shucked aside. It's a statutory right. In *Driver* (2011), this Court held that MCL 600.2301 can't cure the plaintiff's failure to serve an NOI during a lawsuit and before the limitation period expired on a claim against a nonparty. 490 Mich at 255. In *Tyra* (2015), this Court held that MCL 600.2301 can't cure plaintiffs' failure to wait the NOI period before filing their complaints. 498 Mich at 92. Both opinions emphasized that allowing the amendment "'would deprive defendants of their statutory right to a timely NOI followed by the appropriate notice waiting period." *Tyra*, 498 Mich at 92, quoting *Driver*, 490 Mich at 255 (cleaned up).

The same is true here. Applying MCL 600.2301 in any case like this one would mean that defendants don't get the statutorily required notice before a claim is put into litigation. So, as *Tyra* stated, "ignoring the defects in these cases would not be 'for the furtherance of justice' and would affect defendants' 'substantial rights.'" *Tyra*, 498 Mich at 92, quoting MCL 600.2301.

That isn't necessarily the case when the plaintiff's NOI suggested or referred to a theory. E.g., *Bush*, 484 Mich at 179-180. In those cases, the defendant arguably had some opportunity to consider the claim unencumbered by litigation. See *id.* at 178. Not here though. And not in any case in which the plaintiff raises an entirely new theory during litigation. In those cases, allowing amendment under MCL 600.2301 can do only one thing—deprive defendants of their statutory right.

There's a simple solution for plaintiffs, like Kostadinovski, who discover a new claim during litigation: send a new NOI. The NOI statute specifically contemplates new

NOIs. The litigation on the original claims can proceed or be stayed during the notice-waiting period. If the claim isn't settled during that period, the plaintiff can move to amend his complaint having complied with the NOI statute (and *Gulley-Reaves*).[40]

Here, Kostadinovski made no attempt to comply with the NOI requirement for his new theory. Allowing amendment would deprive defendants of their "statutory right" to receive an NOI describing the claim before it's put into litigation. *Tyra*, 498 Mich at 92; MCL 600.2912b(4). As a matter of law, MCL 600.2301 cannot ever save a medical-malpractice claim that wasn't even alluded to in an NOI. So the analysis in Court of Appeals' published opinion is wrong. If this Court reaches this issue despite Kostadinovski's waiver, it should grant leave to appeal and reverse.

Conclusion and Relief Requested

The Court of Appeals clearly erred because it reversed the trial court under abuse-of-discretion review based on an issue that Kostadinovski waived. The Court of Appeals' analysis of the applicability of MCL 600.2301 is also wrong. MCL 600.2301 cannot ever apply when a plaintiff seeks to raise a new theory that wasn't referenced in his NOI. Accordingly, this Court should either peremptorily reverse or grant leave to appeal and then reverse the Court of Appeals' judgment.

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[40] Below, Kostadinovski suggested that the "appropriate course" would be to first amend the complaint and then amend the NOI. Kostadinovski Court of Appeals Brief, p. 22. That's backwards. The notice precedes the complaint. MCL 600.2912b(1). That's the entire point of the notice. Accordingly, if Kostadinovski was going to seek refuge through amending his NOI, he had to do it before amending his complaint. But he didn't and it's too late to ask for that relief now.

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Dated: December 5, 2017

STATE OF MICHIGAN

IN THE SUPREME COURT

DRAGO KOSTADINOVSKI and
BLAGA KOSTADINOVSKI,
as Husband and Wife,

Plaintiffs-Appellees,

v.

STEVEN D. HARRINGTON, M.D. and
ADVANCED CARDIOTHORACIC
SURGEONS, P.L.L.C.,

Defendants-Appellants.

Supreme Court No.
Court of Appeals No. 333034

Macomb County Circuit Court
No. 14-2247-NH
Hon. Kathryn A. Viviano

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CERTIFICATE OF SERVICE

Beverly A. Sutherlin says that on the 5th day of December, 2017, she served a copy of *Notice of Filing Supreme Court Application for Leave to Appeal* on

Office of the Clerk
Macomb County Circuit Court
40 N. Main
Mount Clemens, MI 48043

Angela DiSessa, District Clerk
Michigan Court of Appeals
201 W. Big Beaver Rd, Ste 800
Troy, MI 48084-4127

via TrueFiling.

/s/ Beverly A. Sutherlin

EXHIBIT 1

STATE OF MICHIGAN

MACOMB COUNTY CIRCUIT COURT

DRAGO KOSTADINOVSKI
and BLAGA KOSTADINOVSKI,
as husband and wife,

Plaintiff,

Case No. 2014-2247-NH

vs.

STEVEN D. HARRINGTON, M.D., and
ADVANCED CARDIOTHORACIC
SURGEONS, P.L.L.C.,

Defendants.

_____/

OPINION AND ORDER

This matter is before the Court on plaintiffs' motion to amend complaint, as well as defendants' motion to strike allegations not contained in the notice of intent, complaint, and affidavits of merit and for summary disposition pursuant to MCR 2.116(C)(10).

I. Background

This case involves allegations of medical malpractice. On December 14, 2011, defendant Steven D. Harrington, M.D. performed a DaVinci mitral valve repair surgery on plaintiff Drago Kostadinovski. During the procedure, Mr. Kostadinovski suffered a stroke. On December 9, 2013, plaintiffs sent their notice of intent ("NOI") to Dr. Harrington and defendant Advanced Cardiothoracic Surgeons, PLLC ("ACS"). On October 13, 2015, plaintiffs' filed their complaint in this matter alleging a count of

medical malpractice against Dr. Harrington, a count of vicarious liability against ACS, and a count for loss of consortium against defendants.

On March 21, 2016, defendants filed the instant motion to strike allegations not contained in the notice of intent, complaint, and affidavits of merit and for summary disposition pursuant to MCR 2.116(C)(10). The same day, plaintiffs filed the instant motion for leave to file an amend complaint alleging two additional ways that Dr. Harrington breached the applicable standards of care that were not included in their notice of intent, complaint, and affidavits of merit.

At a hearing on March 28, 2016, the Court heard the parties' arguments on plaintiffs' motion for leave to file an amended complaint and took the matter under advisement. On April 25, 2015, the Court heard the parties' arguments on defendants' aforementioned motion to strike and motion for summary disposition. After the hearing, the parties submitted a stipulated order dismissing plaintiffs' claims of negligence and theory of causation as plead in their notice of intent, complaint, and affidavits of merit with prejudice. Thus, the Court need not address defendants' arguments relating their motion for summary disposition of plaintiffs' claims raised in their original filings.

However, the stipulated order did not dispose of plaintiffs' motion for leave to file amended complaint. Because defendants' motion strike allegations not contained in the notice of intent, complaint, and affidavits of merit raises the same issues as plaintiffs' motion for leave to file amended complaint, the Court shall consider the parties' motions together.

II. Arguments of the Parties

Plaintiffs argue that the Court should grant their motion for leave to amend their

complaint to add an additional claims to Count I of their complaint alleging negligence against Dr. Harrington for failing to adequately monitor Mr. Kostadinovski's hypotension during the operation and failing to transfuse the patient so as to maintain his blood pressure. Plaintiffs contend that because their original complaint raised claims of negligence associated with the December 14, 2011, surgery performed by Dr. Harrington, the proposed amended claims arise out of the same "conduct, transaction, or occurrence" that was the subject of their original complaint pursuant to MCR 2.1118(D). Additionally, plaintiffs submit that there is no undue delay, bad faith, previous inadequate amendments, undue prejudice, or futility.

Defendants aver that the proposed amendment does not relate back to the original filing of the pleadings under MCR 2.118(D) because plaintiffs seek to add completely new allegations and theories, which were not part and parcel of those claims in the NOI, complaint, or affidavit of merit. Specifically, defendants argue that the original pleading focused solely on the preoperative assessment and testing of the patient, which predated the mitral valve surgery performed by Dr. Harrington. Defendants claim that the new allegations have nothing to do with the preoperative work-up or assessment of the patient's arterial tree or use of the EndoClamp in the absence of a preoperative CT angiography. Additionally, defendants state that even if the proposed amendment "relates back" to the complaint, the proposed amendment should be denied due to undue delay, undue prejudice, and futility.

III. Law & Analysis

MCR 2.118(D) provides that "[a]n amendment that adds a claim or defense relates back to the date of the original pleading if the claim or defense asserted in the

amended pleading arose out of the conduct, transaction, or occurrence set forth, or attempted to be set forth, in the original pleading."

In *Doyle v Hutzel Hosp*, 241 Mich App 206; 615 NW2d 759 (2000), a plaintiff filed a complaint against defendants on October 14, 1996, asserting a medical malpractice claim arising out of a 1994 post-operative infection. *Id.* at 208. Specifically, plaintiff alleged that defendants negligently caused and allowed foreign material to remain in her body at the close of surgery. *Id.* at 209. In February of 1998, after the expiration of the applicable period of limitation pursuant to MCL 600.5805(4), defendants moved for summary disposition asserting that plaintiff could not support her allegation that foreign material was left in the surgical site during surgery or that any material was removed on August 16, 1994, was a foreign body. *Id.* In response, plaintiff moved to amend her complaint, seeking to add two theories of professional negligence against defendants. *Id.* at 2010. Namely, plaintiff's proposed amended complaint alleged that her post-operative infection was caused by defendants' performing the surgery without eliminating the possibility of prior infection in her ankle, and by defendants' failure to properly diagnose and treat the post-operative infections following surgery. *Id.*

The Michigan Court of Appeals held that the trial court erred in concluding that the amended complaint did not relate back to the original complaint pursuant to MCR 2.118(D). *Id.* at 211. The Court noted that "[i]t is well settled that the amended pleading can introduce new facts, new theories, or even a different cause of action as long as the amendment arises from the same transactional setting that was set forth in the original pleading." *Id.* at 212-213. The Court concluded the trial court's undue reliance on the temporal differences between the theories alleged in the amendment and original

complaints clouded the broader analysis required by MCR 2.118. *Id.* at 218-220. The Court found that because "all the new theories of negligence proposed in the amended complaint arose out of the same conduct, transaction, or occurrence set forth in her original complaint, namely, the infection of plaintiff's right hip following surgery," the amendments relate back to the original complaint. *Id.* at 211, 220.

In this case, plaintiffs' NOI alleged that that Dr. Harrington negligently failed to obtain preoperative diagnostic tests, including a CT angiogram, which would have enabled him "to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp as was performed on December 14, 2011." Defendants' Exhibit 2, Plaintiffs' NOI at 12-13. According to plaintiffs' NOI, "[h]ad Dr. Harrington performed the proper preoperative testing, he would have aborted the procedure and/or would have use a different technique aside from the use of an EndoClamp." *Id.* at 13. The allegations in plaintiffs' complaint mirror the allegations made in the NOI. However, plaintiffs contend that during the course of discovery it was revealed that Dr. Harrington negligently failed to monitor Mr. Kostadinovski's hypotension during the operation and failed to transfuse him.

Given the foregoing, the Court is satisfied that the proposed amendment arises from the same transactional setting that was set forth in the original pleading. Indeed, the new theory of negligence proposed in the amended complaint arises out of the same conduct, transaction, or occurrence set forth in the original complaint – the DaVinci mitral valve repair surgery performed on December 14, 2011. Consequently,

plaintiffs' proposed amended complaint relates back to the date the original complaint was filed – October 13, 2015 – pursuant to MCR 2.118(D).

Despite the conclusion that plaintiffs' proposed amended complaint relates back to the date of the original complaint was filed, the Court must further determine whether plaintiffs' motion to amend should nevertheless be denied, as argued by defendants.[1]

MCR 2.118(A)(2) provides that "[e]xcept as provided in subrule (A)(1), a party may amend a pleading only by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires." *Kemerko Clawson, LLC v RxIV Inc*, 269 Mich App 347, 352; 711 NW2d 801 (2005). "Because a court should freely grant leave to amend a complaint when justice so requires, a motion to amend should ordinarily be denied only for particularized reasons." *Wormsbacher v Seaver Title Co*, 284 Mich App 1, 8; 772 NW2d 827 (2009). "Reasons that justify denying leave to amend include undue delay, bad faith or dilatory motive, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the defendant, or futility." *Id.*

MCL 600.2912b(1) requires that the plaintiff in a medical malpractice action give the defendant written notice of the plaintiff's intent to file a claim at least 182 days before commencing a medical malpractice action against the defendant. *Tyra v Organ*

[1] The fact that plaintiffs' proposed amendment arises from the same conduct, transaction, or occurrence set forth in the original complaint – and thus, relates back to the date of the filing of the original complaint pursuant to MCR 2.118(D) – does not eliminate plaintiffs' duty to provide defendants with the requisite statutory notice pursuant to MCL 600.2912b. In other words, the determination that the new allegations in the proposed amended complaint relate back to the original complaint merely provides that the proposed amended complaint is deemed to have been filed on the same date the original complaint was filed – October 13, 2015. The relation back rule simply has no bearing on plaintiff's obligation to comply with MCL 600.2912b. For this reason, plaintiffs' reliance on *Doyle* is misplaced to the extent plaintiffs suggest the relation back rule allows amendments in a medical malpractice action despite the failure to comply with MCL 600.2912b.

Procurement Agency of Michigan, 498 Mich 68, 78; 869 NW2d 213 (2015). MCL 600.2912b(4) mandates that a NOI contain a statement of the following:

> (a) The factual basis for the claim.
> (b) The applicable standard of practice or care alleged by the claimant.
> (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
> (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.
> (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.
> (f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.

"A claimant is not required to ensure that such statements are correct, but the claimant must make a good-faith effort to set forth the required information with that degree of specificity which will put the potential defendants on notice as to the nature of the claim against them." *Tousey v Brennan*, 275 Mich App 535, 539; 739 NW2d 128 (2007). "The details need only allow the potential defendants to understand the claimed basis of the impending malpractice action." *Id.*(internal citation and punctuation omitted). "[A] plaintiff cannot commence an action before he or she files a notice of intent that contains all the information required under § 2912b(4)." *Boodt v Borgess Med Ctr*, 481 Mich 558, 562-563; 751 NW2d 44 (2008).

In *Gulley-Reaves v Baciewicz*, 260 Mich App 478; 679 NW2d 98 (2004), the plaintiff's NOI set forth as the basis of her claim a particular surgical procedure that resulted in damage to her vocal cords which "likely occurred because of the inexperience of the medical students or resident, who actually performed the procedure." *Id.* at 480. However, when the plaintiff filed her complaint, she included claims based on the anesthesia that was administered during the surgery. *Id.* at 481. On appeal, the Court held that "the notice did not set forth the minimal requirements to

identify that the anesthesia was a potential cause of plaintiff's injury." *Id.* at 487. The Court also noted that "[d]efendant hospital was not given the opportunity to engage in any type of settlement negotiation with regard to the anesthesia claims because it was not given notice of the existence of any such claim." *Id.* at 488. Therefore, the Court held that the trial court erred in denying defendants' motion for summary disposition because "[p]laintiff failed to provide notice of the claim of breach of the standard of care with regard to the administration of anesthesia" as required by MCL 600.2912b(4)(c). *Id.* at 490.

In this case, as previously stated, plaintiffs' NOI alleged that that Dr. Harrington negligently failed to obtain preoperative diagnostic tests which would have enabled him "to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp as was performed on December 14, 2011." Defendants' Exhibit 2, Plaintiffs' NOI at 12-13. According to plaintiffs' NOI, "[h]ad Dr. Harrington performed the proper preoperative testing, he would have aborted the procedure and/or would have use a different technique aside from the use of an EndoClamp." *Id.* at 13.

Although the allegations in plaintiffs' complaint mirrored the allegations made in the NOI, now plaintiffs seek to amend their complaint to include allegations that Dr. Harrington negligently failed to monitor Mr. Kostadinovski's hypotension during the operation and failed to transfuse him. The Court finds that plaintiffs' NOI did not set forth the minimal requirements to provide notice of the claim of breach of the standard of care with regard to the failure to monitor hypotension levels during the operation and

the failure to transfuse the patient was a potential cause of injury as required by MCL 600.2912b. Accordingly, defendants were not given the opportunity to engage in any type of settlement negotiation with regard to the hypotension and transfusion claims because they were not given notice of the existence of any such claims. Even if plaintiffs had included these new allegations in their original complaint, defendants lacked the requisite notice mandated by MCL 600.2912b because they were not raised in the NOI.

Plaintiffs' failure to adhere to the statutory mandates renders the new allegations contained in the proposed amended complaint futile, as these new allegations of medical malpractice must fail as a matter of law. See *Boodt*, 481 Mich at 562-563; *Gulley-Reaves*, 260 Mich App 490. Therefore, plaintiffs' motion to amend is properly denied.[2]

IV. Conclusion

For the reasons set forth above, plaintiffs' motion to amend complaint is DENIED. Defendants' motion to strike allegations not contained in the notice of intent, complaint, and affidavits of merit and for summary disposition pursuant to MCR 2.116(C)(10) is thus rendered moot. Pursuant to MCR 2.602(A)(3), this Opinion and Order resolves the last pending claim and closes the case.

IT IS SO ORDERED.

DATED: APR 29 2016

Kathryn A. Viviano

Hon. Kathryn A. Viviano
Circuit Judge

Cc:

[2] Given the Court's determination that plaintiffs' may not amend their complaint, defendants' motion to strike allegations not contained in the notice of intent, complaint, and affidavits of merit is moot and need not be addressed separately.

EXHIBIT 2

STATE OF MICHIGAN

COURT OF APPEALS

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI,

Plaintiffs-Appellants/Cross-Appellees,

v

STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, PLLC,

Defendants-Appellees/Cross-Appellants.

FOR PUBLICATION
October 24, 2017
9:05 a.m.

No. 333034
Macomb Circuit Court
LC No. 2014-002247-NH

Before: BORRELLO, P.J., and MURPHY and RONAYNE KRAUSE, JJ.

MURPHY, J.

Plaintiffs Drago Kostadinovski and Blaga Kostadinovski, husband and wife, appeal as of right the trial court's order denying their motion to file an amended medical malpractice complaint after the court had earlier granted summary disposition in favor of defendants Steven D. Harrington, M.D. (the doctor), and Advanced Cardiothoracic Surgeons, P.L.L.C., on plaintiffs' original complaint. Mr. Kostadinovski suffered a stroke during the course of a mitral-valve-repair (MVR) surgery performed by the doctor in December 2011. Plaintiffs timely served defendants with a notice of intent to file a claim (NOI), MCL 600.2912b, and later timely filed a complaint for medical malpractice against defendants, along with the necessary affidavit of merit, MCL 600.2912d. In the NOI, affidavit of merit, and the complaint, plaintiffs set forth multiple theories with respect to how the doctor allegedly breached the standard of care in connection with the surgery. After nearly two years of litigation and the close of discovery, plaintiffs' experts effectively disavowed and could no longer endorse the previously-identified negligence or breach-of-care theories and the associated causation claims, determining now, purportedly on the basis of information gleaned from discovery, that the doctor had instead breached the standard of care by failing to adequately monitor Mr. Kostadinovski's hypotension (low blood pressure) and transfuse him, resulting in the stroke. Plaintiffs agreed to the dismissal of the existing negligence allegations and complaint, but sought to file an amended complaint that included allegations regarding Mr. Kostadinovski's hypotensive state and the failure to adequately transfuse him. While the trial court believed that any amendment would generally relate back to the filing date of the original complaint, the court ruled that an amendment would

be futile, considering that the existing NOI would be rendered obsolete because it did not reference the current malpractice theory. And, absent the mandatory NOI, a medical malpractice action could not be sustained. The denial of plaintiffs' motion to amend the complaint, in conjunction with the dismissal of the original complaint, effectively ended plaintiffs' lawsuit. On appeal, plaintiffs challenge the denial of their motion to amend the complaint. Defendants cross appeal, arguing that, aside from futility, amendment of the complaint should not be permitted because plaintiffs unduly delayed raising the new negligence theory and because such a late amendment would prejudice defendants. On the strength of *Bush v Shabahang*, 484 Mich 156; 772 NW2d 272 (2009), we hold that the trial court, as opposed to automatically not allowing plaintiffs to amend their complaint because of the NOI conundrum that would be created, was required to assess whether the NOI defect could be disregarded or cured by an amendment of the NOI under MCL 600.2301 in the context of futility analysis. Accordingly, we reverse and remand for further proceedings under MCL 600.2301.

I. BACKGROUND

On December 9, 2013, plaintiffs served defendants with the NOI, asserting that on December 14, 2011, the doctor had performed robotic-assisted MVR surgery on Mr. Kostadinovski and that, as subsequently determined, Mr. Kostadinovski suffered a stroke during the course of the procedure. The NOI listed six specific theories with respect to the manner in which the doctor allegedly breached the applicable standard of care relative to the surgery and preparation for the surgery, along with identifying related causation claims.[1] On June 4, 2014, an expert for plaintiffs executed an affidavit of merit that listed the same six negligence theories outlined in the NOI in regard to the alleged breaches of the standard of care. On June 5, 2014, plaintiffs filed their medical malpractice complaint against defendants, along with the affidavit of merit, alleging that the doctor breached the standard of care in the six ways identified in the NOI and affidavit of merit. The causation claims were also identical in all three legal documents. In resolving this appeal, it is unnecessary for us to discuss the particular nature of these negligence and causation theories.

On March 21, 2016, defendants filed a motion for summary disposition, arguing that, as revealed during discovery, plaintiffs' expert witnesses could not validate or support the six negligence theories set forth in the NOI, affidavit of merit, and the complaint. On that same date, March 21, 2016, plaintiffs filed a motion to amend their complaint. Plaintiffs asserted that discovery had recently been completed and that discovery showed that Mr. Kostadinovski "was in a hypotensive state during the operation and was not adequately transfused." According to plaintiffs, this evidence was previously unknown and only came to light following the deposition of the perfusionist, the continuing deposition of the doctor, and the depositions of plaintiffs' retained experts. Plaintiffs sought to amend the complaint to allege negligence against the doctor "for failing to adequately monitor Mr. Kostadinovski's hypotension during the operation and

[1] A seventh nonspecific allegation indicated that the doctor had "failed to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process."

failing to transfuse the patient so as to maintain the patient's blood pressure." On March 28, 2016, a hearing was held on plaintiffs' motion to amend the complaint, and the trial court decided to take the matter under advisement. On April 25, 2016, a hearing was conducted on defendants' motion for summary disposition, at which time plaintiffs agreed to the dismissal of their original complaint, given that their theories of negligence now lacked expert support, as did the causation claims that had been linked to the defunct negligence theories.[2] Plaintiffs' motion to amend the complaint remained pending.

On April 29, 2016, the trial court issued a written opinion and order denying plaintiffs' motion to amend the complaint. The court initially ruled, under MCR 2.118(D), that because the proposed amendment of plaintiffs' complaint arose from the same transactional setting as that covered by the original complaint, any amendment would relate back to the date that the original complaint was filed for purposes of the period of limitations. However, after citing language in MCR 2.118 and associated caselaw regarding principles governing the amendment of pleadings, along with MCL 600.2912b on notices of intent, the trial court ruled:

> The Court finds that plaintiffs' NOI did not set forth the minimal requirements to provide notice of the claim of breach of the standard of care with regard to the failure to monitor hypotension levels during the operation and the failure to transfuse the patient as a potential cause of injury as required by MCL 600.2912b. Accordingly, defendants were not given the opportunity to engage in any type of settlement negotiation with regard to the hypotension and transfusion claims because they were not given notice of the existence of any such claims. Even if plaintiffs had included these new allegations in their original complaint, defendants lacked the requisite notice mandated by MCL 600.2912b because they were not raised in the NOI.
>
> Plaintiffs' failure to adhere to the statutory mandates renders the new allegations contained in the proposed amended complaint futile, as these new allegations of medical malpractice must fail as a matter of law. Therefore, plaintiffs' motion to amend is properly denied. [Citations omitted.]

Plaintiffs appeal as of right.

II. ANALYSIS

A. STANDARDS OF REVIEW

This Court reviews for an abuse of discretion a trial court's ruling on a motion for leave to file an amended pleading. *Franchino v Franchino*, 263 Mich App 172, 189; 687 NW2d 620 (2004). "Thus, we defer to the trial court's judgment, and if the trial court's decision results in an

[2] By order dated April 25, 2016, the trial court indicated that plaintiffs' allegations of negligence and causation as stated in the NOI, complaint, and affidavit of merit were dismissed with prejudice.

outcome within the range of principled outcomes, it has not abused its discretion." *Wormsbacher v Phillip R Seaver Title Co, Inc*, 284 Mich App 1, 8; 772 NW2d 827 (2009) (citation omitted). "A trial court . . . necessarily abuses its discretion when it makes an error of law." *People v Al-Shara*, 311 Mich App 560, 566; 876 NW2d 826 (2015). We review de novo matters of statutory construction, as well as questions of law in general. *Wells Fargo Bank, NA v SBC IV REO, LLC*, 318 Mich App 72, 89-90; 896 NW2d 821 (2016).

B. AMENDMENT OF PLEADINGS – BASIC PRINCIPLES

A pleading may be amended once as a matter of course if done so within a limited period; otherwise, "a party may amend a pleading only by leave of the court or by written consent of the adverse party." MCR 2.118(A)(1) and (2). Plaintiffs were no longer entitled to amend their complaint as of right, necessitating their motion to amend the complaint. MCR 2.118(A)(2) provides that "[l]eave shall be freely given when justice so requires." Therefore, a motion to amend should ordinarily be granted. *Weymers v Khera*, 454 Mich 639, 658; 563 NW2d 647 (1997). A court must give a particularized reason for denying leave to amend a pleading, and acceptable reasons for denial include undue delay, bad faith or dilatory motive by the party seeking leave, repeated failures to cure deficiencies after previously-allowed amendments, undue prejudice to the nonmoving party, and futility. *Miller v Chapman Contracting*, 477 Mich 102, 105; 730 NW2d 462 (2007); *Wormsbacher*, 284 Mich App at 8. The amendment of a pleading is properly deemed futile when, regardless of the substantive merits of the proposed amended pleading, the amendment is legally insufficient on its face. *Hakari v Ski Brule, Inc*, 230 Mich App 352, 355; 584 NW2d 345 (1998); *Gonyea v Motor Parts Fed Credit Union*, 192 Mich App 74, 78; 480 NW2d 297 (1991).

With respect to the question whether an amendment of a pleading relates back to the date that the original pleading was filed, MCR 2.118(D) provides:

> An amendment that adds a claim or a defense relates back to the date of the original pleading if the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth, or attempted to be set forth, in the original pleading. In a medical malpractice action, an amendment of an affidavit of merit or affidavit of meritorious defense relates back to the date of the original filing of the affidavit.

In *Doyle v Hutzel Hosp*, 241 Mich App 206, 218-219; 615 NW2d 759 (2000), this Court analyzed MCR 2.118(D) and the caselaw regarding the amendment of pleadings, holding:

> When placed in context against a backdrop providing that leave to amend pleadings must be freely granted, MCR 2.118(A)(2), the principle to be gleaned from these cases is the necessity for a broadly focused inquiry regarding whether the allegations in the original and amended pleadings stem from the same general "conduct, transaction, or occurrence." The temporal setting of the allegations is not, in and of itself, the determinative or paramount factor in resolving the propriety of an amendment of the pleadings, and undue focus on temporal differences clouds the requisite broader analysis.

It does not matter whether the proposed amendment introduces new facts, a different cause of action, or a new theory, so long as the amendment springs from the same transactional setting as that pleaded originally. *Id.* at 215.

C. MEDICAL MALPRACTICE ACTIONS – NOTICE OF INTENT TO FILE A CLAIM

The focus of the trial court's ruling and the arguments of the parties concern the NOI and the fact that plaintiffs' proposed amended complaint set forth a negligence or breach-of-care theory that was not recited in the NOI. MCL 600.2912b provides, in pertinent part:

> (1) Except as otherwise provided in this section, a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced.
>
> * * *
>
> (4) The notice given to a health professional or health facility under this section shall contain a statement of at least all of the following:
>
> (a) The factual basis for the claim.
>
> (b) The applicable standard of practice or care alleged by the claimant.
>
> (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
>
> (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.
>
> (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.
>
> (f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.
>
> * * *
>
> (6) After the initial notice is given to a health professional or health facility under this section, the tacking or addition of successive 182-day periods is not allowed, irrespective of how many additional notices are subsequently filed for that claim and irrespective of the number of health professionals or health facilities notified.

In *Bush*, 484 Mich at 174, our Supreme Court noted the legislative intent behind MCL 600.2912b, observing:

> The stated purpose of § 2912b was to provide a mechanism for promoting settlement without the need for formal litigation, reducing the cost of medical malpractice litigation, and providing compensation for meritorious medical malpractice claims that would otherwise be precluded from recovery because of litigation costs. [Citation, quotation marks, and ellipsis omitted.]

D. DISCUSSION AND HOLDING

Our analysis today entails the question whether the *Bush* Court's application of MCL 600.2301 in a case involving a defective NOI governs the approach to be applied in the context of the procedural circumstances present in the instant case, or whether two published opinions from this Court that arguably lend some support for defendants' position are controlling. MCL 600.2301 provides in full:

> The court in which any action or proceeding is pending, has power to amend any process, pleading or proceeding in such action or proceeding, either in form or substance, for the furtherance of justice, on such terms as are just, at any time before judgment rendered therein. The court at every stage of the action or proceeding shall disregard any error or defect in the proceedings which do not affect the substantial rights of the parties.

In *Gulley-Reaves v Baciewicz*, 260 Mich App 478, 479-482; 679 NW2d 98 (2004), the plaintiff served an NOI on the defendants, claiming medical malpractice in the performance of a mediastinoscopy, and the plaintiff later filed a complaint against the defendants, along with two supporting affidavits of merit. The *Gulley-Reaves* panel summarized the defendants' response as follows:

> Defendants filed a motion for summary disposition challenging plaintiff's compliance with the statutory requirements for providing presuit notice of intent to file a medical-malpractice-action. Specifically, defendants asserted that the notice of intent alleged malpractice with respect to the surgical procedure only. Upon the filing of the medical-malpractice complaint, defendants learned that plaintiff was also challenging the administration of the anesthesia during the surgical procedure. The notice of intent allegedly did not comply with the statutory requirements because it did not advise of the claimed wrongdoing with regard to the anesthesia. That is, it did not allege a breach of the standard of care and proximate cause based on anesthesia given during the surgical procedure. [*Id.* at 482-483.[3]]

The *Gulley-Reaves* panel agreed that the NOI was defective, because it "did not set forth the minimal requirements to identify that the anesthesia was a potential cause of plaintiff's

[3] The plaintiff's affidavits of merit and complaint in *Gulley-Reaves* did reveal a malpractice claim based on the faulty administration of anesthesia. *Gulley-Reaves*, 260 Mich App at 481-482.

injury[,]" and because the NOI "was silent with regard to any breach of the standard of care during the administration of anesthesia." *Id.* at 487. This Court held that the trial court erred in denying the defendants' motion for summary disposition, given that the "[p]laintiff failed to provide notice of the claim of breach of the standard of care with regard to the administration of anesthesia as required by" the NOI statute. *Id.* at 490. The opinion did not include any discussion whatsoever of MCL 600.2301, and the *Bush* opinion was still five years on the horizon.

In *Bush*, a case involving claims of medical malpractice arising out of surgery to repair an aortic aneurysm, the NOI, amongst other alleged defects, purportedly failed to identify the particular actions taken by physician assistants and the nursing staff that breached the standard of care, failed to state how the hiring and training practices of one of the defendants breached the standard of care, and failed to set forth some necessary theories of causation. *Bush*, 484 Mich at 161-162, 179-180. The *Bush* Court rejected the proposition that mandatory dismissal of a medical malpractice action is the sole remedy for a defective NOI or violation of MCL 600.2912b. *Id.* at 170-181. Next, the Court, focusing on the alleged NOI defects, held:

> We agree with the Court of Appeals that these omissions do constitute defects in the NOI. However, we disagree with the Court of Appeals regarding the appropriate remedy. We are not persuaded that the defects . . . warrant dismissal of a claim. These types of defects fall squarely within the ambit of § 2301 and should be disregarded or cured by amendment. It would not be in the furtherance of justice to dismiss a claim where the plaintiff has made a good-faith attempt to comply with the content requirement of § 2912b. A dismissal would only be warranted if the party fails to make a good-faith attempt to comply with the content requirements. Accordingly, we hold that the alleged defects can be cured pursuant to § 2301 because the substantial rights of the parties are not affected, and "disregard" or "amendment" of the defect is in the furtherance of justice when a party has made a good-faith attempt to comply with the content provisions of § 2912b. [*Id.* at 180-181.]

After *Bush* was decided, this Court issued an opinion in *Decker v Rochowiak*, 287 Mich App 666; 791 NW2d 507 (2010). In *Decker*, the plaintiff, by his next friend, filed a medical malpractice action that was predicated on an alleged failure to properly monitor the plaintiff's glucose level; the plaintiff was diagnosed "with cerebral palsy from an early anoxic (lack of oxygen) brain injury." *Id.* at 670-671. After serving his NOI on the defendants and filing his complaint with supporting affidavits of merit, the plaintiff sought leave to file an amended complaint in order to allege 17 specific ways in which the defendants breached the applicable standards of care. *Id.* at 671. This Court summarized the plaintiff's argument in favor of allowing the amended complaint:

> Plaintiff argued that the amendment was proper because (1) discovery remained open and experts had not been deposed, (2) the amendment merely clarified allegations and issues and was made possible after particular information was learned through the discovery process, (3) the clarifications ultimately relate back to the underlying lynch pin of this entire case which is that they did not appropriately monitor and maintain this baby's glucose level, and (4) defendants

> would not be prejudiced by the amendment. [*Id.* (quotation marks and alteration brackets omitted).]

The trial court granted the request to file an amended complaint and subsequently denied various motions for summary disposition filed by the defendants, with this Court granting and consolidating multiple applications for leave to appeal pursued by the defendants. *Id.* at 671-674.

The defendants in *Decker* argued that the plaintiff's amended complaint had asserted new theories of medical malpractice that were not contained in the NOI; therefore, amendment of the complaint should not have been allowed or the amended complaint should have been summarily dismissed pursuant to *Gulley-Reaves*. *Decker*, 287 Mich App at 679-682. The *Decker* panel found that the plaintiff, while providing some details and clarification, had not actually alleged any new negligence or causation claims in the amended complaint that were not already encompassed by the claims in the NOI, so the purpose of the notice requirement was realized. *Id.* at 677-682. The Court observed that "[t]his is not a case where, as in *Gulley-Reaves*, the plaintiff set forth a totally new and different potential cause of injury in an amended complaint compared to the potential cause of injury set forth in her NOI, e.g., the manner in which a particular surgical procedure was performed compared to the manner in which anesthesia was administered during the surgery." *Id.* at 680-681. This statement by the *Decker* panel might lead one to believe at first glance that, when a totally new breach-of-care or causation theory actually is pursued, as in the instant case, summary dismissal or disallowance of an amended complaint would be appropriate.

We conclude that *Bush* controls our analysis. If MCL 600.2301 is implicated and potentially applicable to save a medical malpractice action when an NOI is defective because of a failure to include negligence or causation theories required by MCL 600.2912b(4), then, by analogy, MCL 600.2301 must likewise be implicated and potentially applicable when an NOI is deemed defective because it no longer includes the negligence or causation theories required by MCL 600.2912b(4) and alleged in the complaint, due to a post-complaint change in the theories being advanced by a plaintiff as a result of information gleaned from discovery. There is no sound or valid reason that the principles from *Bush* should not be applied here. Indeed, as a general observation, factual circumstances are even more compelling for the invocation of MCL 600.2301 when an NOI is not defective from the outset but becomes defective because discovery has shed new light on the case and given rise to a new liability theory.[4]

Assuming that *Gulley-Reaves* supports defendants' position here, it was issued prior to *Bush* and the Court did not entertain an argument under MCL 600.2301. Second, the Court in *Decker* also did not entertain an argument under MCL 600.2301, nor would it have been necessary for the panel to have even reached an argument under MCL 600.2301, given the nature of its ruling that no new claims were asserted in the amended complaint that were not already accounted for in the NOI. The Court simply distinguished *Gulley-Reaves*, and we can only

[4] We note that plaintiffs contemplated such a possibility when they included language in the NOI that the doctor failed to adhere to the standard of care as might be revealed through discovery.

speculate whether it would have applied the *Bush* § 2301 analysis had it determined that new claims were being raised or whether it would have applied the *Gulley-Reaves* opinion and dismissed the case.[5] Ultimately, *Decker* did not address the impact of *Bush* and MCL 600.2301 on a case involving new theories of negligence and causation that differed from those identified in the NOI. Moreover, *Bush* is controlling Supreme Court precedent, trumping decisions by this Court. See MCR 7.215(J)(1).[6]

We do find it necessary to address *Driver v Naini*, 490 Mich 239, 243; 802 NW2d 311 (2011), wherein our Supreme Court held "that a plaintiff is not entitled to amend an original NOI *to add nonparty defendants* so that the amended NOI relates back to the original filing for purposes of tolling the statute of limitations[.]" (Emphasis added.) The *Driver* Court rejected the plaintiff's argument that he should be allowed to amend his original NOI pursuant to *Bush* and MCL 600.2301. *Id.* at 251-259. The Court in *Driver* explained:

> *Bush* is inapplicable to the present circumstances. At the outset we note that the holding in *Bush* that a defective yet timely NOI could toll the statute of limitations simply does not apply here because CCA [nonparty defendant] never received a timely, albeit defective, NOI. More importantly, and contrary to the dissent's analysis, the facts at issue do not trigger application of MCL 600.2301. . . .
>
> * * *
>
> By its plain language, MCL 600.2301 only applies to actions or proceedings that are *pending*. Here, plaintiff failed to commence an action against CCA before the six-month discovery period expired, and his claim was therefore barred by the statute of limitations. An action is not pending if it cannot be commenced. In *Bush*, however, this Court explained that an NOI is part of a medical malpractice proceeding. The Court explained that, since an NOI must be given before a medical malpractice claim can be filed, the service of an NOI is a part of a medical malpractice 'proceeding. As a result, MCL 600.2301 applies to

[5] The *Decker* panel was aware of *Bush*, considering that it cited *Bush* with respect to explaining the purpose of an NOI. *Decker*, 287 Mich App at 675-676.

[6] Plaintiffs argue that MCL 600.2912b simply requires the service of an NOI before suit is filed and that once this is accomplished through the service of a proper and compliant NOI, *as judged at the time suit is filed and by the language in the original complaint*, the requirements of the statute have been satisfied, absent the need to revisit the NOI even if a new theory of negligence or causation is later developed that was not included in the NOI and that forms the basis of an amended complaint. If this were the law, the entire analysis in *Decker* would have been completely unnecessary, because a proper and compliant NOI had been served on the defendants, as judged on the date the original complaint was filed and by the language in that complaint. Moreover, the approach suggested by plaintiffs would undermine the legislative intent and purpose behind MCL 600.2912b.

> the NOI process. Although plaintiff gave CCA an NOI, he could not file a medical malpractice claim against CCA because the six-month discovery period had already expired. Service of the NOI on CCA could not, then, have been part of any proceeding against CCA because plaintiff's claim was already time-barred when he sent the NOI. A proceeding cannot be pending if it was time-barred at the outset. Therefore, MCL 600.2301 is inapplicable because there was no action or proceeding pending against CCA in this case. [*Driver*, 490 Mich at 253-254 (citations, quotation marks, alteration brackets, and emphasis omitted.]

The *Driver* Court later emphasized that the *Bush* opinion concerned "the *content* requirements of MCL 600.2912b(4)." *Id.* at 257.

In the instant case, the NOI was timely served on defendants, as was the complaint, an amended NOI would not entail adding a new party, and we, like the *Bush* Court, are concerned with the content requirements of MCL 600.2912b(4). Therefore, *Driver* is factually and legally distinguishable and MCL 600.2301 can be considered.

For purposes of guidance on remand, we provide the following direction. The trial court is to engage in an analysis under MCL 600.2301 to determine whether amendment of the NOI or disregard of the prospective NOI defect would be appropriate.[7] If the trial court concludes that amendment or disregard of the defect would not be proper under MCL 600.2301, the court's prior futility analysis relative to plaintiff's motion to amend the complaint shall stand and the motion to amend the complaint shall be denied, ending the case, subject of course to appeal on the § 2301 analysis. If the trial court determines that MCL 600.2301 supports amendment of the NOI or disregard of the NOI defect, thereby negating the court's prior futility analysis, amendment of the complaint shall be allowed, with one caveat. Aside from futility, defendants had proffered additional reasons why amendment of the complaint should not be allowed, i.e., undue delay and undue prejudice, see *Miller*, 477 Mich at 105, which were not reached by the trial court and are repeated by defendants in their appellate brief as alternative bases to affirm. The trial court shall entertain those arguments if the court rules in plaintiffs' favor on MCL 600.2301.

Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction. Having fully prevailed on appeal, plaintiffs are awarded taxable costs under MCR 7.219.

/s/ William B. Murphy
/s/ Stephen L. Borrello
/s/ Amy Ronayne Krause

[7] We conclude that it would not be proper for us to conduct the analysis under MCL 600.2301 in the first instance; that, at least initially, is the trial court's role, which we shall not intrude upon.

EXHIBIT 3

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,

Plaintiffs,

v

STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

Defendants.

14-2247-NH

Case No. 14- -NH
Hon. JOHN C. FOSTER

JEFFREY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)
Attorneys for Plaintiff
3200 Greenfield, Suite 260
Dearborn, MI 48120
(313) 961-0130 Fax: 8178

There is no other pending or resolved civil action arising out of the transaction or occurrence alleged in the complaint

JEFFERY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)

COMPLAINT AND DEMAND FOR JURY TRIAL

NOW COMES Plaintiff herein, Drago Kostadinovski and Blaga Kostadinovski, as Husband and Wife, by and through their attorneys, MORGAN & MEYERS, PLC, and states as their cause of action against the above-named Defendants the following:

1. The amount in controversy is in excess of TWENTY FIVE THOUSAND ($25,000) DOLLARS.

2. At all times pertinent to this Complaint, Drago Kostadinovski (hereinafter "Mr. Kostadinovski") was a resident of the County of Macomb, State of Michigan.

3. At all times pertinent to this Complaint, Blaga Kostadinovski (hereinafter "Mrs. Kostadinovski") was a resident of the County of Macomb, State of Michigan.

4. At all times pertinent to this Complaint, Steven D. Harrington, M.D. was a physician doing business in the County of Macomb, State of Michigan.

5. At all times pertinent to this Complaint, Advanced Cardiothoracic Surgeons, PLLC was a Michigan Limited Liability Company doing business in the County of Macomb, State of Michigan.

6. At all times pertinent to this Complaint, Dr. Harrington was an employee/agent at Advanced Cardiothoracic Surgeons P.L.L.C.

7. In paragraphs 8 – 67 as set forth below, Plaintiffs make reference to statements contained in the medical records of various health care providers. The recitation of these factual statements should not be interpreted as an admission by Plaintiffs as to the factual authenticity or truthfulness of these statements. The statements are set forth below to provide context as to the violations of the standards of care, also described below.

8. Prior to the events described in this Complaint, Mr. Kostadinovski was a married man who was able to perform all of his activities of daily living independently as well as mobilize independently.

9. Prior to the events described in this Complaint, Mr. Kostadinovski was able to care for himself independently while living with his wife.

10. On July 30th, 2011, Drago Kostadinovski, a 70-year old male, date of birth, May 10th, 1941, presented to the Henry Ford Macomb Hospital Emergency Department stating that he had just completed an echocardiogram at the Henry Ford Out-Patient Clinic located at Fifteen Mile Road and Ryan.

11. While at the clinic, Mr. Kostadinovski had informed the staff that he was having a hard time breathing and at times was having difficulty swallowing pills and drinking water.

12. Mr. Kostadinovski indicated that the staff at the Henry Ford Clinic sent him to the Emergency Department for further examination. Upon arrival at the Henry Ford Macomb Hospital Emergency Department, Mr. Kostadinovski was seen by Arti Bajpai, M.D. and Patrician L. Milani, MD who indicated that the Mr. Kostadinovski presented with difficulty breathing and was unable to breathe at times during the night. These symptoms began approximately three days prior to the July 30th, 2011 admission and fluctuated in intensity.

13. Mr. Kostadinovski's medical history included hypertension, hyperlipidemia, diabetes and a social history of tobacco smoking, noting that Mr.Kostadinovski had quit tobacco one year ago. The impression of the ER physicians was dyspnea, with a plan to rule out cardiac causes, including myocardial infarction, angina, CHF. It was noted that Dr. Milani had discussed the case with Dr. Abas Jafri, Mr. Kostadinovski's primary care physician.

14. After Mr. Kostadinovski was examined in the Emergency Department, he was admitted to the in-patient telemetry unit and his care was transitioned to Maria B. Perry, M.D.

15. On August 1st, 2011, Mr. Kostadinovski underwent an echocardiogram for the clinical indication of CHF. The ordering physician was noted as Marius Laurinaitis, MD. The interpretation included demonstration of right ventricle with normal size and function. Left ventricle size, thickness and function were normal. The left ventricular ejection fraction was normal. The mitral leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with a moderate mitral regurgitation, and posterior mitral leaflet changes consistent with mitral prolapse and some mal opposition with moderate to severe MR.

16. Following the results of the echocardiogram, a transesophageal echocardiogram was recommended and performed in a two-dimensional fashion.

17. Again, the mitral valve leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation.

18. A duplex extra cranial artery study was performed, which indicated 40 to 59 percent stenosis in the right internal carotid artery with homogenous plaque found. Less than 40 percent stenosis was noted in the left internal carotid artery. The study was interpreted by Rizk Youssef, D.O.

19. On August 3rd, 2011, under the attending care of Dr. Perry, and by order of Dr. Majid Al-Zagoum, Mr. Kostadinovski underwent a persantine myocardial perfusion scan with a noted history of chest pain, hypertension, diabetes and hypercholesterolemia. The report was read by Khurram Rashid, M.D., with an impression noting no scintigraphic evidence of reversible ischemia and with normal left ventricular wall motion and an ejection fraction of 69 percent.

20. On August 3rd, 2011, an exercise stress test was performed and interpreted by Durgadas Narla, M.D. The impression was negative per statin stress EKG, with occasional PBCs, stable vital signs which correlated with the myocardial scan report.

21. On August 4th, 2011, another two-dimensional transesophageal echocardiogram was performed. It was performed under the order of Dr. Al-Zagoum and interpreted by Dr. Al-Zagoum with an interpretation of moderate to severe mitral regurgitation. The mitral regurgitant jet was noted to be eccentrically directed. Prolapse of the anterior mitral leaflet ejection fraction was noted at 60 to 65 percent.

22. On August 5th, 2011, Dr. Perry requested a consultation by Steven D. Harrington, M.D. The reason for the consultation was mitral insufficiency and dyspnea with exertion.

23. In Dr. Harrington's consultation note, Dr. Harrington noted the history of the present illness as a 70-year old male who speaks limited English, originally from Macedonia.

24. Dr. Harrington indicated that his son-in-law was at bedside and translated the conversation. Mr. Kostadinovski reported that he had been having increased shortness of breath and reported episodes of dyspnea while lying flat. He also reported episodes of reflux for the past several days; however, he denied any other accompanying symptoms.

25. Dr. Harrington's assessment of Mr. Kostadinovski at the date of the consultation was: (1) acute exacerbation of congestive heart failure secondary to mitral regurgitation; (2), status post-echocardiogram, no current TEE report is in the chart; however TD echocardiogram revealed the mitral valve leaflets to be thickened with

hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation. Ejection fraction was estimated at 55 to 60 percent, three negative persantine stress EKG, 40 to 59 percent stenosis to the right internal carotid artery and less than 40 percent stenosis to the left internal carotid artery.

26. Dr. Harrington's plan was to order a transesophageal echocardiogram report which would be reviewed by Dr. Harrington. Dr. Harrington noted that Mr. Kostadinovski would need cardiac catheterization prior to a mitral valve repair/replacement. The cardiac catheterization would be to rule out coronary artery disease and the possible need for myocardial revascularization, as well as mitral valve repair/replacement. The note was dictated by Ryan Ramales, Physician's Assistant and was approved by Dr. Harrington on August 7th, 2011.

27. On August 4th, 2011, Mr. Kostadinovski was discharged from Henry Ford Macomb Hospital, noting that at 2D echo was suggestive of severe mitral valve insufficiency and was confirmed by transesophageal echocardiogram. The discharge summary included an evaluation by Dr. Harrington in the Cardiovascular Surgery Department and that out-patient follow-up was recommended. Mr. Kostadinovski was to follow up with Dr. Jafari in three to four days, to follow up with Dr. Al-Zagoum in five to seven days and to follow up with Dr. Harrington in ten to 14 days.

28. On September 12, 2011, Mr. Kostadinovski underwent cardiac catheterization at the Cardiac Catheterization Laboratory at Henry Ford Macomb Hospital. The cardiac catheterization was performed and reported by Dr. Al-Zagoum. Findings were noted as a normal left main coronary artery. "Left anterior descending artery has one major diagonal branch which appeared to be normal and the left anterior descending itself

appeared to be within normal limits. The left circumflex artery had one major obtuse marginal artery branch which appeared to be normal and the right coronary artery was a dominant artery with no significant disease noted." Left ventriculography was done using pigtail catheter with ejection fraction about 35 to 40 percent with global hypokinesia.

29. On December 9th, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital under the care of Dr. Steven D. Harrington for a pre-surgical evaluation for mitral valve repair/replacement with robotic assistance.

30. During this consultation report, Dr. Harrington noted the September 12, 2011 cardiac catheterization by Dr. Al-Zagoum, in which Mr. Kostadinovski was found to have normal coronary arteries and moderate left ventricular dysfunction. The ejection fraction was noted to be between 35 and 40 percent, and at that point, Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

31. An x-ray of the chest was performed on this date with a clinical history of "some difficulty in breathing/pre-operative study", which demonstrated no significant interval change from the prior x-ray which was performed on July 30, 2011.

32. No CT study of the chest, nor any CT angiogram was ordered or reviewed by Dr. Harrington on December 9, 2011 on the pre-surgical clearance admission, nor was any CT study or CT angiogram ordered and reviewed prior to the DaVinci mitral valve repair surgery on December 14, 2011.

33. On December 9, 2011, Dr. Harrington's assessment was mitral insufficiency with normal coronary arteries and diabetes myelitis type II. As far as prior testing, Dr. Harrington reported that on August 8th, 2011, Mr. Kostadinovski underwent a transesophageal echocardiogram which revealed severe mitral valve prolapse, prolapse of

the anterior mitral leaflet with moderate to severe mitral regurgitation, and also noted that the tricuspid valve was normal and had mild tricuspid regurgitation.

34. On December 9, 2011, Dr. Harrington did not recommend nor order that Mr. Kostadinovski undergo any further echocardiogram testing, CTA or other angiogram studies to determine any extent of atherosclerotic process or atherosclerosis in the aortic arch at this time. Informed consent was reported to be given after risks were discussed, and Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

35. On December 14, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital for a DaVinici mitral valve complex repair with posterior leaflet resection and 28-millimeter, CG future band annuloplasty and ligation of left atrial appendage.

36. The operation was performed by Steven D. Harrington, M.D. with the assistance of Shelly Klein, PA-C. Anesthesiology was performed by Dr. Zhang, who also performed a transesophageal echocardiogram (TEE), which was noted independently, as performed by anesthesia, although the body of the operative report indicates that Dr. Harrington interpreted and utilized the data from the intra-operative TEE study.

37. In the operative findings, Dr. Harrington noted that there was severe mitral insufficiency with torn P2 posterior segment allowing prolapse of both anterior and posterior leaflets.

38. Dr. Harrington indicated that the repair had been accomplished with quadrangular resection of the P2 segment, primary repair, and a 28 millimeter CG future band angioplasty.

39. Dr. Harrington indicated that Mr. Kostadinovski was in normal sinus rhythm pre-operatively and post-operatively and had "excellent" left ventricle function. Dr.

Harrington further noted that post-operative repair showed no mitral insufficiency and no evidence of mitral stenosis.

40. During the procedure, Mr. Kostadinovski was placed in the supine position, prepared and draped in a sterile fashion and the right groin was opened, exposing the femoral artery and vein, and the was cannulated with a 23 arterial hemostatic valve catheter and a 25 venous Heart Port catheter in the vein, all positioned with transesophageal echo guidance.

41. At this point, the DaVinci robot was brought into position and docked and the EndoAortic clamp was brought into position with transesophageal echo guidance.

42. Cardiopulmonary bypass was instituted and the EndoAortic clamp was inflated and the heart was arrested with administration of HTK cardioplegia injected into the aortic root. With the robot, the diaphragmatic stitch retraction was placed followed by opening the pericardium on and pericardial traction sutures.

43. At that point, Dr. Harrington noted the inter-arterial groove was then developed and opened and left atrial retractor placed exposing the valve. Dr. Harrington noted "obvious P2 segment that was torn and that was resected with quadrangular resection and repaired with a primary repair with No. 4 Gortex suture."

44. After further repair, the valve was tested to see that it was secured and it was with no leak after injection of 250 milliliters of saline. The EndoAortic clamp was released and the patient returned spontaneously to a sinus rhythm.

45. Dr. Harrington noted adequate rewarming and reperfusion and a weaning from cardiopulmonary bypass and decannulization without difficulty, requiring no inotropes,

only a small amount of neo-synephrine, which was quickly weaned off. After the operation, Mr. Kostadinovski was transferred to the Intensive Care Unit for recovery.

46. Dr. Harrington noted that a peri-operative transesophageal echocardiogram showed excellent cooptation of leaflets, no mitral insufficiency, normal sinus rhythm, and stable left ventricular function.

47. Upon transfer to the Intensive Care Unit, Mr. Kostadinovski's post-operative vital signs were recorded as follows: temperature 101.9 axillary, pulse 86, respirations 10, blood pressure 134/55, and O_2 sat a hundred percent on FI O_2 of 40 percent.

48. It was noted that Mr. Kostadinovski did not awaken post-operatively, and on December 15th, at 01:15 a.m., the nursing staff noted the presence of tonic-clonic movements lasting approximately 65 seconds. At that time, Mr. Kostadinovski remained unresponsive, despite attempts to stimulate him. He did not open his eyes or follow commands.

49. It was also noted during the night of December 15, 2011, that Mr. Kostadinovski had 15 seconds of involuntary movements involving the left-side of his face and his eyes, prompting the administration of Keppra 500 milligrams, IV piggyback and Ativan, 2 milligrams, IV.

50. Rajindar K. Sikand, M.D. was consulted who formulated a plan to rule out anesthesia versus neurological event post-op after being called to consult a non-responsive patient who was unable to follow commands and noted to be lethargic occurring overnight on the first day post-op.

51. On December 15, 2011, at approximately 14:00 hours, it was noted that medical staff had witnessed spontaneous movement of Mr. Kostadinovski's right arm, after

he grasped on two occasions with his left hand and nursing staff noted some tremors in Mr. Kostadinovski's "saddle region." At that point, Dr. Wilma E. Agnello-Dimitrijevic, M.D., a neurologist, was consulted regarding Mr. Kostadinovski's condition.

52. Dr. Agnello-Dimitrijevic noted at that time that Mr. Kostadinovski did not have a history of TIA stroke, seizure or syncope, and no known history of neuropathy or retinopathy.

53. On December 15, 2011, a CT of the brain was performed without contrast, and it was reported as demonstrating evidence of acute ischemic infarct within the right cerebral hemisphere, having the appearance of water shed distribution involving the right anterior cerebral artery distribution. There was no noted evidence of hemorrhage. That study was interpreted by Frank Randazzo, M.D., and it was also noted in the consultation note that Dr. Agnello-Dimitrijevic also interpreted the study and noted evidence of extensive sulcal effacement involving the right front temporal and parietal lobe, consistent with infarction, most notably in the ACA territory. There is also evidence of involvement of the MCA territory. There was no evidence of midline shift and no evidence of hemorrhage. No obvious sulcal effacement is noted in the left hemisphere.

54. An electroencephalogram (EEG) was performed on December 16, 2011 to rule out seizure. The impression of the reviewing physician, Dr. Shyam Moudgil, M.D. indicated the impression of an abnormal EEG, suggestive of diffuse cortical neuronal dysfunction, as seen in moderate encephalopathy and clinical correlation as to the etiology of the encephalopathy was recommended.

55. Dr. Agnello-Dimitrijevic's notable impressions were (1) encephalopathy, multifactorial secondary to embolic stroke/sedation, (2) acute right anterior cerebral artery

and middle cerebral artery, ischemic infarcts, (3) mitral regurgitation, status post mitral valve repair, among other observations.

56. Dr. Agnello-Dimitrijevic noted clinically that Mr. Kostadinovski had evidence of not only right hemispheric ischemic stroke, but involvement of the contralateral corticospinal tracts. There was also evidence of not only an aberrant mentation, but bilateral Babinski reflexes sustained bilateral ankle clonus and left Hoffmann reflexes.

57. It was noted by Dr. Agnello-Dimitrijevic at the time of this initial consultation that she discussed the findings with the patient's family at length and noted Mr. Kostadinovski's guarded prognosis and ultimate need for extensive rehabilitation.

58. An additional CT of the head and cervical spine, without contrast, and three-dimensional reconstruction with PACS was performed on December 16, 2011, which was compared to the prior examination from December 15th, 2011. The impression of Frank Randazzo, M.D. was acute right-sided water shed and interior cerebral artery infarctions, as before with no significant interval change.

59. On December 17, 2011, a CT of the head, without contrast, was performed and compared with the December 15, 2011 study. The impression was right-cerebral hemispheric stroke with edema and developing areas of encephalomalacia with the ventricular system remaining patent and left anterior cerebral artery distribution infarction, as well.

60. Also noted was concern for brain stem ischemic change and likely remote ischemic change of the right cerebellum and paranasal sinus findings. This was interpreted by Michele Keys, D.O.

61. On December 17th, 2011, the consultation of neurosurgeon Vittorio Morreale, M.D. was requested for the reason of a large infarct with mass affect. Dr. Morreale indicated that Mr. Kostadinovski developed infarct immediately with surgery and has remained intubated since. He further noted that Mr. Kostadinovski is non-verbal and has had dense left hemiplegia since surgery. It was Dr. Morreale's impression that Mr. Kostadinovski did not require intracranial pressure monitoring and that this treatment plan was discussed with Dr. Agnello-Dimitrijevic.

62. There is a rehabilitation consultation note from David K. Davis, M.D later on during Mr. Kostadinovski's hospital stay. Dr. Davis noted that radiology was reviewed that indicated that a head CT showed right cerebral edema with ischemia, anterior, middle and posterior cerebral arteries and subarachnoid hemorrhage was also seen with partial uncal herniation due to edema in the right temporal horn and ischemia right-posterior cerebral artery is also seen. The impression of Dr. Davis was a patient that was status post-acute large stroke, right side of the brain with dense left-sided weakness and left hemineglect and dysphagia, poor trunk control and very low functional level at the time of the consultation which was approximately 13 days from stroke.

63. Also, at the time of Dr. Davis' consultation, it was noted that Mr. Kostadinovski's function status was too low for in-patient rehab, which would signify a much longer time needed for recovery. Dr. Davis also indicated to continue PT and OT, and because his criteria would not meet in-patient rehab admission criteria, Dr. Davis would recommend sub-acute rehab admission at this time until his condition improved.

64. Mr. Kostadinovski remained on ventilator support until he was extubated on December 23rd, 2011 and was eventually transferred to a cardiac step-down unit where he

had an extended hospital stay before ultimately being discharged on January 4, 2012 to Hartford Rehabilitation Center.

65. Mr. Kostadinovski's discharge summary included diagnosis of ventilator dependent respiratory failure, right anterior cerebral artery infarct, for which he was being discharged to Hartford Rehab for further rehabilitation.

66. Mr. Kostadinovski was discharged to Hartford Rehab Clinic with instructions to follow-up with Drs. Harrington, Al-Zagoum and Jafari.

67. Mr. Kostadinovski underwent a pro-longed rehabilitation course and no longer has the ability to perform his ADL's and live a life as he did prior to the date of the surgery. Mr. Kostadinovski has suffered all other damages and injuries as noted throughout this Complaint.

COUNT I: MEDICAL NEGLIGENCE OF STEVEN D. HARRINGTON, M.D.

The Plaintiffs hereby restate, reallege, and incorporate by reference each and every allegation set forth above and further states, in the alternative, the following:

68. At all times pertinent to this Notice, the standard of care applicable to Steven D. Harrington, M.D., required him to maintain the standard of care of his peers within the professional community of cardiothoracic surgeons.

69. The requirements of the standard of care included, but were not limited to, the

a. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

b. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

c. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington was required to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

d. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington was required to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

e. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

f. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

g. Dr. Harrington was required to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

70. Notwithstanding said obligations, and in breach thereof, Defendant Dr. Harrington violated the standard of care applicable in the manner set forth below:

a. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

b. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

c. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington failed to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

d. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington failed to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

e. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

f. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

g. Dr. Harrington failed to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

71. Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violations described above by Dr. Harrington.

72. As a direct and proximate result of each breach of the standard of care as outlined above, Drago Kostadinovski suffered and continues to suffer a permanent impairment to his cognitive capacity rendering him incapable of making independent responsible life decisions and permanently incapable of independently performing the activities of normal daily living. As such, Drago Kostadinovski is entitled to the higher noneconomic damage cap pursuant to MCLA 600.1483.

73. As a result of each breach of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer pain and suffering, disability and disfigurement, emotional distress, anxiety, denial of social pleasures and enjoyments, humiliation, medical expenses, loss of earnings, and a loss of earning capacity.

74. As a direct and proximate result each violation of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain and suffering, loss of ability to perform all activities of daily living, along with all other damages and injuries as noted within this complaint.

75. Had Dr. Harrington followed the standard of care and performed and appreciated a full history and physical, ordered and reviewed all necessary pre-operative radiographic testing and/or studies, including, but not limited to, x-rays, CT studies, CT angiograms, and any and all other necessary radiographic testing, he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp as was performed on December 14, 2011. Had

Dr. Harrington performed the proper preoperative testing, he would have aborted the procedure and/or would have used a different technique aside from the use of an EndoClamp. Had Dr. Harrington declined to perform this elective mitral valve repair and/or refrained from using the EndoClamp, thrombus, clot or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

76. Had Dr. Harrington followed the standard of care and properly monitored and observed the intraoperative transesophageal echocardiogram (TEE), he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the procedure and/or used a different technique aside from the EndoClamp approach. Had Dr. Harrington declined to perform this elective mitral valve repair at this point and/or refrained from using the EndoClamp, thrombus, clot, or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

77. Had Dr. Harrington followed the standard of care and used the care and technique of a reasonable surgeon in performing the DaVinci mitral valve repair surgery, he would have avoided disrupting any calcium, thrombus or other build-up in the arterial

tree during the operation and he would have avoided causing the above referenced injuries and damages to Mr. Kostadinovski. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the surgery and/or used a different approach and/or surgical technique while performing the December 14, 2011 DaVinci mitral valve repair surgery. Had Dr. Harrington maintained the standard of care in this respect, thrombus, clot or calcification would not have broken loose or formed, causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

78. Mrs. Kostadinovski, as the legal wife of Mr. Kostadinovski, is entitled to loss of consortium damages, which are the direct and proximate result of the damages and injuries described above caused by Dr. Harrington. Mr. Kostadinovski along with his wife, are entitled to damages as are deemed fair and just, including, but not limited to the following: reasonable compensation for the pain and suffering incurred by Mr. Kostadinovski, economic loss, emotional damage, loss of consortium, all medical expenses incurred along with a loss of economic opportunity and all other damages and injuries listed previously within this complaint.

79. Had Dr. Harrington followed the standard of care in all respects as outlined above, Mr. Kostadinovski would not have suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain-suffering, loss of ability to perform all activities of daily living, as well as all damages and injuries previously noted within this complaint.

WHEREFORE, Plaintiffs respectfully request that this Honorable Court enter judgment against the Defendants in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the Plaintiff is deemed to be entitled.

COUNT II: VICARIOUS LIABILITY OF ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

The plaintiffs hereby restate, reallege, and incorporate by reference each and every allegation set forth above and further states, in the alternative, the following:

80. At all times pertinent to this Complaint, Dr. Steven D. Harrington, M.D., was an agent, ostensible agent, servant and/or employee of Advanced Cardiothoracic Surgeons, PLLC. As such, Advanced Cardiothoracic Surgeons, PLLC are vicariously liable for the negligent acts and/or omissions of Dr. Harrington as more fully described above, as well as the injuries and damages flowing from said acts and/or omissions.

WHEREFORE, plaintiffs respectfully request that this Honorable Court enter judgment against the defendants, jointly and severally, and in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the plaintiff is deemed to be entitled.

COUNT III: LOSS OF CONSORTIUM

The plaintiffs hereby restate, re-allege and incorporate by reference each and every allegation set forth above and further state, in the alternative, the following:

81. At all times pertinent to this Complaint, Blaga Kostadinovski was the lawfully wedded wife of Drago Kostadinovski.

82. As a direct and proximate result of the injuries and damages experienced by Drago Kostadinovski, Blaga Kostadinovski, has suffered the loss of her husband's consortium, society, and companionship; emotional distress and anxiety, past, present, and future; and denial of social pleasures and enjoyments, past, present, and future.

WHEREFORE, plaintiffs respectfully request that this Honorable Court enter judgment against the defendants, jointly and severally, and in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the plaintiff is deemed to be entitled.

RESPECTFULLY SUBMITTED,

MORGAN & MEYERS, PLC

BY _____

JEFFREY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)
Attorneys for Plaintiff
3200 Greenfield, Suite 260
Dearborn, Michigan 48120-1802
(313) 961-0130

DATED: June 5, 2014

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,

Plaintiffs,

v

Case No. 14- -NH
Hon.

STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

Defendants.
_____/

JEFFREY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)
Attorneys for Plaintiff
3200 Greenfield, Suite 260
Dearborn, MI 48120
(313) 961-0130 Fax: 8178

DEMAND FOR JURY TRIAL

NOW COMES Plaintiffs herein, Drago Kostadinovski and Blaga Kostadinovski, as Husband and Wife, by and through their attorneys, MORGAN & MEYERS, PLC, and hereby demands a jury trial in the above-captioned cause of action.

MORGAN & MEYERS, PLC

BY _____
JEFFREY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)
Attorneys for Plaintiff
3200 Greenfield, Suite 260
Dearborn, Michigan 48120-1802
(313) 961-0130

DATED: June 5, 2014

EXHIBIT 4

NOTICE OF INTENT TO FILE CLAIM
PURSUANT TO MCL 600.2912(B)

Henry Ford Macomb Hospital
Resident Agent: Edith L. Eisenmann
Governance Office
1 Ford Place, 5B
Detroit, MI 48202

Henry Ford Macomb Hospital
Resident Agent: Edith L. Eisenmann
15885 19 Mile Road
Mt. Clemens, MI 48043

Steven D. Harrington, M.D.
Advanced Cardiothoracic Surgeons
38800 Garfield
Clinton Township, MI 48038

Advanced Cardiothoracic Surgeons, PLLC
Registered Agent: Steven D. Harrington
49474 Compass Pte
New Baltimore, MI 48047

Steven D. Harrington, M.D.
49474 Compass Pte
New Baltimore, MI 48047

This Notice is intended to apply to the above-referenced health care professionals, entities, and/or facilities as well as their employees or agents, actual or ostensible, who were involved in the treatment of Drago Kostadinovski, hereinafter referred to as Mr. Kostadinovski, date of birth 05/10/1941.

At all times pertinent to this Notice Steven D. Harrington, M.D., was an agent, an apparent agent, ostensible agent, servant and/or employee of Henry Ford Macomb Hospital, hereinafter referred to as HFMH. As such, HFMH is vicariously liable for the negligent acts and/or omissions of Dr. Harrington, as more fully noted below.

At all times pertinent to this Notice Steven D. Harrington, M.D. was an agent, an apparent agent, ostensible agent, servant and/or employee of Advanced Cardiothoracic Surgeons, PLLC. As such, Advanced Cardiothoracic Surgeons, PLLC is vicariously liable for the negligent acts and/or omissions of Dr. Harrington, as more fully noted below.

At all times pertinent to this Notice of Intent, the unknown nurses described in the body of this Notice were agents, apparent agents, ostensible agents, servants and/or employees of HFMH. As such, HFMH is vicariously liable for the negligent acts and/or omissions of the unknown nurses, as more fully noted below.

It is difficult to determine based upon the medical records reviewed whether Mr. Kostadinovski was being evaluated and treated by resident physicians, attending physicians or consulting physicians, or a combination thereof. In the event it is later determined that Mr. Kostadinovski was being evaluated and treated by resident physicians, attending physicians and/or consulting physicians, other than those listed in the body of this Notice, Henry Ford Macomb Hospital shall be vicariously liable for the acts and/or omissions of those currently unknown physicians.

The statements set forth in this Notice are based upon entries made within the records of Henry Ford Macomb Hospital, Dr. Harrington, Dr. Al-Zagoum, M.D., Cardiovascular Institute of Michigan, Advanced Cardiothoracic Surgeons, PLLC, the Hartford Rehabilitation Institute and Dr. Abas Jafri. At this time, Claimant does not admit the truth of any of the statements contained within the medical records of Henry Ford Macomb Hospital, Dr. Harrington, Dr. Al-Zagoum, M.D., Cardiovascular Institute of Michigan, Advanced Cardiothoracic Surgeons, PLLC, the Hartford Rehabilitation Institute and Dr. Abas Jafri, and the recitation of various factual information as set forth below should not be interpreted as an adoption of any of those statements.

It should also be noted that the records of Henry Ford Macomb Hospital, Dr. Harrington, Dr. Al-Zagoum, M.D., Cardiovascular Institute of Michigan, Advanced Cardiothoracic Surgeons, PLLC, the Hartford Rehabilitation Institute and Dr. Abas Jafri, are illegible and/or unintelligible in many instances. As such, it is impossible for claimant to plead all theories of liability against Dr. Harrington at this time. Similarly, it is impossible for claimant to give a complete factual background regarding the treatment of Drago Kostadinovski given the illegibility and unintelligibility of the records of Henry Ford Macomb Hospital, Dr. Harrington, Dr. Al-Zagoum, M.D., Cardiovascular Institute of Michigan, Advanced Cardiothoracic Surgeons, PLLC, the Hartford Rehabilitation Institute and Dr. Abas Jafri.

Attorneys retained by Drago Kostadinovski are unable to more specifically plead additional violations of the standard of care, as well as actions which should have been taken to comply with the standard of care, due to the inability of counsel to take the depositions of witnesses involved in this matter, prior to the filing of this Notice. Because of the inability to conduct depositions, it is impossible for claimant to plead all theories of liability with more specificity at this time.

A. FACTUAL BASIS FOR CLAIM

Prior to the events described in this Notice, Mr. Kostadinovski was a married man who was able to perform all of his activities of daily living independently as well as mobilize independently. Prior to the events described in this Notice, Mr. Kostadinovski was able to care for himself independently while living with his wife.

On July 30th, 2011, Drago Kostadinovski, a 70-year old male, date of birth, May 10th, 1941, presented to the Henry Ford Macomb Hospital Emergency Department stating that he had just completed an echocardiogram at the Henry Ford Out-Patient Clinic located at Fifteen Mile Road and Ryan. While at the clinic, Mr. Kostadinovski had informed the staff that he was having a hard time breathing and at times was having difficulty swallowing pills and drinking water.

Mr. Kostadinovski indicated that the staff at the Henry Ford Clinic sent him to the Emergency Department for further examination. Upon arrival at the Henry Ford Macomb Hospital Emergency Department, Mr. Kostadinovski was seen by Arti Bajpai, M.D. and

Patrician L. Milani, MD who indicated that the Mr. Kostadinovski presented with difficulty breathing and was unable to breathe at times during the night. These symptoms began approximately three days prior to the July 30th, 2011 admission and fluctuated in intensity.

Mr. Kostadinovski's medical history included hypertension, hyperlipidemia, diabetes and a social history of tobacco smoking, noting that Mr.Kostadinovski had quit tobacco one year ago. The impression of the ER physicians was dyspnea, with a plan to rule out cardiac causes, including myocardial infarction, angina, CHF. It was noted that Dr. Milani had discussed the case with Dr. Abas Jafri, Mr. Kostadinovski's primary care physician.

After Mr. Kostadinovski was examined in the Emergency Department, he was admitted to the in-patient telemetry unit and his care was transitioned to Maria B. Perry, M.D.

On August 1st, 2011, Mr. Kostadinovski underwent an echocardiogram for the clinical indication of CHF. The ordering physician was noted as Marius Laurinaitis, MD. The interpretation included demonstration of right ventricle with normal size and function. Left ventricle size, thickness and function were normal. The left ventricular ejection fraction was normal. The mitral leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with a moderate mitral regurgitation, and posterior mitral leaflet changes consistent with mitral prolapse and some mal opposition with moderate to severe MR.

Following the results of the echocardiogram, a transesophageal echocardiogram was recommended and performed in a two-dimensional fashion. Again, the mitral valve leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation. A duplex extra cranial artery study was performed, which indicated 40 to 59 percent stenosis in the right internal carotid artery with homogenous plaque found. Less than 40 percent stenosis was noted in the left internal carotid artery. The study was interpreted by Rizk Youssef, D.O.

On August 3rd, 2011, under the attending care of Dr. Perry, and by order of Dr. Majid Al-Zagoum, Mr. Kostadinovski underwent a persantine myocardial perfusion scan with a noted history of chest pain, hypertension, diabetes and hypercholesterolemia. The report was read by Khurram Rashid, M.D., with an impression noting no scintigraphic evidence of reversible ischemia and with normal left ventricular wall motion and an ejection fraction of 69 percent.

On August 3rd, 2011, an exercise stress test was performed and interpreted by Durgadas Narla, M.D. The impression was negative per statin stress EKG, with occasional PBCs, stable vital signs which correlated with the myocardial scan report.

On August 4th, 2011, another two-dimensional transesophageal echocardiogram was performed. It was performed under the order of Dr. Al-Zagoum and interpreted by Dr. Al-Zagoum with an interpretation of moderate to severe mitral regurgitation. The mitral regurgitant jet was noted to be eccentrically directed. Prolapse of the anterior mitral leaflet ejection fraction was noted at 60 to 65 percent.

On August 5th, 2011, Dr. Perry requested a consultation by Steven D. Harrington, M.D. The reason for the consultation was mitral insufficiency and dyspnea with exertion. In Dr. Harrington's consultation note, Dr. Harrington noted the history of the present illness as a 70-year old male who speaks limited English, originally from Macedonia. Dr. Harrington indicated that his son-in-law was at bedside and translated the conversation. Mr. Kostadinovski reported that he had been having increased shortness of breath and reported episodes of dyspnea while lying flat. He also reported episodes of reflux for the past several days; however, he denied any other accompanying symptoms.

Dr. Harrington's assessment of Mr. Kostadinovski at the date of the consultation was: (1) acute exacerbation of congestive heart failure secondary to mitral regurgitation; (2), status post-echocardiogram, no current TEE report is in the chart; however TD echocardiogram revealed the mitral valve leaflets to be thickened with hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation. Ejection fraction was estimated at 55 to 60 percent, three negative persantine stress EKG, 40 to 59 percent stenosis to the right internal carotid artery and less than 40 percent stenosis to the left internal carotid artery.

Dr. Harrington's plan was to order a transesophageal echocardiogram report which would be reviewed by Dr. Harrington. Dr. Harrington noted that Mr. Kostadinovski would need cardiac catheterization prior to a mitral valve repair/replacement. The cardiac catheterization would be to rule out coronary artery disease and the possible need for myocardial revascularization, as well as mitral valve repair/replacement. The note was dictated by Ryan Ramales, Physician's Assistant and was approved by Dr. Harrington on August 7th, 2011.

On August 4th, 2011, Mr. Kostadinovski was discharged from Henry Ford Macomb Hospital, noting that at 2D echo was suggestive of severe mitral valve insufficiency and was confirmed by transesophageal echocardiogram. The discharge summary included an evaluation by Dr. Harrington in the Cardiovascular Surgery Department and that out-patient follow-up was recommended. Mr. Kostadinovski was to follow up with Dr. Jafari in three to four days, to follow up with Dr. Al-Zagoum in five to seven days and to follow up with Dr. Harrington in ten to 14 days.

On September 12, 2011, Mr. Kostadinovski underwent cardiac catheterization at the Cardiac Catheterization Laboratory at Henry Ford Macomb Hospital. The cardiac catheterization was performed and reported by Dr. Al-Zagoum. Findings were noted as a normal left main coronary artery. "Left anterior descending artery has one major diagonal branch which appeared to be normal and the left anterior descending itself appeared to be within normal limits. The left circumflex artery had one major obtuse marginal artery branch which appeared to be normal and the right coronary artery was a dominant artery with no significant disease noted." Left ventrioulography was done using pigtail catheter with ejection fraction about 35 to 40 percent with global hypokinesia. The impression was normal coronary arteries and moderate left ventricular dysfunction.

On December 9th, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital under the care of Dr. Steven D. Harrington for a pre-surgical evaluation for mitral valve repair/replacement with robotic assistance. During this consultation report, Dr. Harrington noted the September 12, 2011 cardiac catheterization by Dr. Al-Zagoum, in which Mr. Kostadinovski was found to have normal coronary arteries and moderate left ventricular dysfunction. The ejection fraction was noted to be between 35 and 40 percent, and at that point, Mr. Kostadinovski was scheduled for surgery on December 14, 2011. An x-ray of the chest was performed on this date with a clinical history of "some difficulty in breathing/pre-operative study", which demonstrated no significant interval change from the prior x-ray which was performed on July 30, 2011. The interpreting and reporting radiologist, Joseph Metes, MD also noted that there was no active intrathoracic disease. No CT study of the chest, nor any CT angiogram was ordered or reviewed by Dr. Harrington on December 9, 2011 on the pre-surgical clearance admission, nor was any CT study or CT angiogram ordered and reviewed prior to the DaVinci mitral valve repair surgery on December 14, 2011.

On December 9, 2011, Dr. Harrington's assessment was mitral insufficiency with normal coronary arteries and diabetes myelitis type II. As far as prior testing, Dr. Harrington reported that on August 8th, 2011, Mr. Kostadinovski underwent a transesophageal echocardiogram which revealed severe mitral valve prolapse, prolapse of the anterior mitral leaflet with moderate to severe mitral regurgitation, and also noted that the tricuspid valve was normal and had mild tricuspid regurgitation. On December 9, 2011, Dr. Harrington did not recommend nor order that Mr. Kostadinovski undergo any further echocardiogram testing, CTA or other angiogram studies to determine any extent of atherosclerotic process or atherosclerosis in the aortic arch at this time. Informed consent was reported to be given after risks were discussed, and Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

On December 14, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital for a DaVinici mitral valve complex repair with posterior leaflet resection and 28-millimeter, CG future band annuloplasty and ligation of left atrial appendage. The operation was performed by Steven D. Harrington, M.D. with the assistance of Shelly Klein, PA-C. Anesthesiology was performed by Dr. Zhang, who also performed a transesophageal echocardiogram (TEE), which was noted independently, as performed by anesthesia, although the body of the operative report indicates that Dr. Harrington interpreted and utilized the data from the intra-operative TEE study.

In the operative findings, Dr. Harrington noted that there was severe mitral insufficiency with torn P2 posterior segment allowing prolapse of both anterior and posterior leaflets. Dr. Harrington indicated that the repair had been accomplished with quadrangular resection of the P2 segment, primary repair, and a 28 millimeter CG future band angioplasty. Dr. Harrington indicated that Mr. Kostadinovski was in normal sinus rhythm pre-operatively and post-operatively and had "excellent" left ventricle function. Dr. Harrington further noted that post-operative repair showed no mitral insufficiency and no evidence of mitral stenosis.

In the operative note in the indication for the procedure, Dr. Harrington noted that although this patient presented with minimal symptomatology, the left ventricular dysfunction began to develop and a decision was made to proceed with the repair before allowing any further damage.

During the procedure, Mr. Kostadinovski was placed in the supine position, prepared and draped in a sterile fashion and the right groin was opened, exposing the femoral artery and vein, and the was cannulated with a 23 arterial hemostatic valve catheter and a 25 venous Heart Port catheter in the vein, all positioned with transesophageal echo guidance.

At this point, the DaVinci robot was brought into position and docked and the EndoAortic clamp was brought into position with transesophageal echo guidance. Cardiopulmonary bypass was instituted and the EndoAortic clamp was inflated and the heart was arrested with administration of HTK cardioplegia injected into the aortic root. With the robot, the diaphragmatic stitch retraction was placed followed by opening the pericardium on and pericardial traction sutures.

At that point, Dr. Harrington noted the inter-arterial groove was then developed and opened and left atrial retractor placed exposing the valve. Dr. Harrington noted "obvious P2 segment that was torn and that was resected with quadrangular resection and repaired with a primary repair with No. 4 Gortex suture." After further repair, the valve was tested to see that it was secured and it was with no leak after injection of 250 milliliters of saline. The EndoAortic clamp was released and the patient returned spontaneously to a sinus rhythm.

Dr. Harrington noted adequate rewarming and reperfusion and a weaning from cardiopulmonary bypass and decannulization without difficulty, requiring no inotropes, only a small amount of neo-synephrine, which was quickly weaned off. After the operation, Mr. Kostadinovski was transferred to the Intensive Care Unit for recovery.

Dr. Harrington noted that a peri-operative transesophageal echocardiogram showed excellent cooptation of leaflets, no mitral insufficiency, normal sinus rhythm, and stable left ventricular function.

Upon transfer to the Intensive Care Unit, Mr. Kostadinovski's post-operative vital signs were recorded as follows: temperature 101.9 axillary, pulse 86, respirations 10, blood pressure 134/55, and O_2 sat a hundred percent on FI O_2 of 40 percent. It was noted that Mr. Kostadinovski did not awaken post-operatively, and on December 15th, at 01:15 a.m., the nursing staff noted the presence of tonic-clonic movements lasting approximately 65 seconds. At that time, Mr. Kostadinovski remained unresponsive, despite attempts to stimulate him. He did not open his eyes or follow commands. It was also noted during the night of December 15, 2011, that Mr. Kostadinovski had 15 seconds of involuntary movements involving the left-side of his face and his eyes, prompting the administration of Keppra 500 milligrams, IV piggyback and Ativan, 2 milligrams, IV.

Rajindar K. Sikand, M.D. was consulted who formulated a plan to rule out anesthesia versus neurological event post-op after being called to consult a non-responsive patient who was unable to follow commands and noted to be lethargic occurring overnight on the first day post-op.

On December 15, 2011, at approximately 14:00 hours, it was noted that medical staff had witnessed spontaneous movement of Mr. Kostadinovski's right arm, after he grasped on two occasions with his left hand and nursing staff noted some tremors in Mr. Kostadinovski's "saddle region." At that point, Dr. Wilma E. Agnello-Dimitrijevic, M.D., a neurologist, was consulted regarding Mr. Kostadinovski's condition. Dr. Agnello-Dimitrijevic noted at that time that Mr. Kostadinovski did not have a history of TIA stroke, seizure or syncope, and no known history of neuropathy or retinopathy.

On December 15, 2011, a CT of the brain was performed without contrast, and it was reported as demonstrating evidence of acute ischemic infarct within the right cerebral hemisphere, having the appearance of water shed distribution involving the right anterior cerebral artery distribution. There was no noted evidence of hemorrhage. That study was interpreted by Frank Randazzo, M.D., and it was also noted in the consultation note that Dr. Agnello-Dimitrijevic also interpreted the study and noted evidence of extensive sulcal effacement involving the right front temporal and parietal lobe, consistent with infarction, most notably in the ACA territory. There is also evidence of involvement of the MCA territory. There was no evidence of midline shift and no evidence of hemorrhage. No obvious sulcal effacement is noted in the left hemisphere.

An electroencephalogram (EEG) was performed on December 16, 2011 to rule out seizure. The impression of the reviewing physician, Dr. Shyam Moudgil, M.D. indicated the impression of an abnormal EEG, suggestive of diffuse cortical neuronal dysfunction, as seen in moderate encephalopathy and clinical correlation as to the etiology of the encephalopathy was recommended.

Dr. Agnello-Dimitrijevic's notable impressions were (1) encephalopathy, multifactorial secondary to embolic stroke/sedation, (2) acute right anterior cerebral artery and middle cerebral artery, ischemic infarcts, (3) mitral regurgitation, status post mitral valve repair, among other observations.

Dr. Agnello-Dimitrijevic noted clinically that Mr. Kostadinovski had evidence of not only right hemispheric ischemic stroke, but involvement of the contralateral corticospinal tracts. There was also evidence of not only an aberrant mentation, but bi-lateral Babinski reflexes sustained bilateral ankle clonus and left Hoffmann reflexes. It was noted by Dr. Agnello-Dimitrijevic at the time of this initial consultation that she discussed the findings with the patient's family at length and noted Mr. Kostadinovski's guarded prognosis and ultimate need for extensive rehabilitation.

An additional CT of the head and cervical spine, without contrast, and three-dimensional reconstruction with PACS was performed on December 16, 2011, which was compared to the prior examination from December 15th, 2011. The impression of Frank Randazzo,

M.D. was acute right-sided water shed and interior cerebral artery infarctions, as before with no significant interval change.

On December 17, 2011, a CT of the head, without contrast, was performed and compared with the December 15, 2011 study. The impression was right-cerebral hemispheric stroke with edema and developing areas of encephalomalacia with the ventricular system remaining patent and left anterior cerebral artery distribution infarction, as well.

Also noted was concern for brain stem ischemic change and likely remote ischemic change of the right cerebellum and paranasal sinus findings. This was interpreted by Michele Keys, D.O.

On December 17th, 2011, the consultation of neurosurgeon Vittorio Morreale, M.D. was requested for the reason of a large infarct with mass affect. Dr. Morreale indicated that Mr. Kostadinovski developed infarct immediately with surgery and has remained intubated since. He further noted that Mr. Kostadinovski is non-verbal and has had dense left hemiplegia since surgery. It was Dr. Morreale's impression that Mr. Kostadinovski did not require intracranial pressure monitoring and that this treatment plan was discussed with Dr. Agnello-Dimitrijevic.

There is a rehabilitation consultation note from David K. Davis, M.D later on during Mr. Kostadinovski's hospital stay. Dr. Davis noted that radiology was reviewed that indicated that a head CT showed right cerebral edema with ischemia, anterior, middle and posterior cerebral arteries and subarachnoid hemorrhage was also seen with partial uncal herniation due to edema in the right temporal horn and ischemia right-posterior cerebral artery is also seen. The impression of Dr. Davis was a patient that was status post-acute large stroke, right side of the brain with dense left-sided weakness and left hemineglect and dysphagia, poor trunk control and very low functional level at the time of the consultation which was approximately 13 days from stroke.

Also, at the time of Dr. Davis' consultation, it was noted that Mr. Kostadinovski's function status was too low for in-patient rehab, which would signify a much longer time needed for recovery. Dr. Davis also indicated to continue PT and OT, and because his criteria would not meet in-patient rehab admission criteria, Dr. Davis would recommend sub-acute rehab admission at this time until his condition improved.

Mr. Kostadinovski remained on ventilator support until he was extubated on December 23rd, 2011 and was eventually transferred to a cardiac step-down unit where he had an extended hospital stay before ultimately being discharged on January 4, 2012 to Hartford Rehabilitation Center. Mr. Kostadinovski's discharge summary included diagnosis of ventilator dependent respiratory failure, right anterior cerebral artery infarct, for which he was being discharged to Hartford Rehab for further rehabilitation. Also noted was a new onset seizure disorder, which began on post-op day one.

Mr. Kostadinovski was discharged to Hartford Rehab Clinic with instructions to follow-up with Drs. Harrington, Al-Zagoum and Jafari.

Mr. Kostadinovski underwent a pro-longed rehabilitation course and no longer has the ability to perform his ADL's and live a life as he did prior to the date of the surgery. Mr. Kostadinovski has suffered all other damages and injuries as noted throughout this Notice.

B. THE APPLICABLE STANDARD OF CARE OR PRACTICE ALLEGED

At all times pertinent to this Notice, the standard of care applicable to Dr. Steven D. Harrington required Dr. Harrington to maintain the standard of care of his peers within the professional community of cardiothoracic surgery. The requirements of the standard of care included, but are not limited to, the following:

1. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

2. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

3. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington was required to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

4. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington was required to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

5. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

6. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to use the care and technique of a reasonable surgeon performing

the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

7. Dr. Harrington was required to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

C. THE MANNER THE APPLICABLE STANDARD OF CARE OR PRACTICE WAS BREACHED

Dr. Harrington breached the applicable standard of care in the manner set forth below:

1. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

2. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

3. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington failed to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

4. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington failed to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

5. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

6. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to use the care and technique of a reasonable surgeon performing the DaVinci

mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

7. Dr. Harrington failed to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

D. THE ACTION THAT SHOULD HAVE BEEN TAKEN TO ACHIEVE COMPLIANCE WITH THE STANDARD OF PRACTICE OR CARE

Actions that should have been taken to achieve compliance with the standard of care include, but are not limited, to the following:

1. On December 9, 2011, and continuously thereafter, Dr. Harrington should have performed and appreciated a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

2. On December 9, 2011, and continuously thereafter, Dr. Harrington should have ordered and reviewed any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

3. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington should have refrained from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

4. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington should have evaluated the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consulted all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

5. On December 14, 2011 and continuously thereafter, Dr. Harrington should have immediately aborted the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

6. On December 14, 2011 and continuously thereafter, Dr. Harrington should have used the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

7. Dr. Harrington was should have adhered to any and all additional requirements of the standard of care as may be revealed through the discovery process.

E. THE MANNER IN WHICH THE BREACH OF THE STANDARD OF PRACTICE OR CARE WAS THE PROXIMATE CAUSE OF THE INJURY CLAIMED IN THE NOTICE

Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violations described above by Dr. Harrington and/or the staff at Henry Ford Macomb Hospital.

As a direct and proximate result of each breach of the standard of care as outlined above, Drago Kostadinovski suffered and continues to suffer a permanent impairment to his cognitive capacity rendering him incapable of making independent responsible life decisions and permanently incapable of independently performing the activities of normal daily living. As such, Drago Kostadinovski is entitled to the higher noneconomic damage cap pursuant to MCLA 600.1483.

As a result of each breach of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer pain and suffering, disability and disfigurement, emotional distress, anxiety, denial of social pleasures and enjoyments, humiliation, medical expenses, loss of earnings, and a loss of earning capacity.

As a direct and proximate result each violation of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain and suffering, loss of ability to perform all activities of daily living, along with all other damages and injuries as noted within this notice.

Had Dr. Harrington followed the standard of care and performed and appreciated a full history and physical, ordered and reviewed all necessary pre-operative radiographic testing and/or studies, including, but not limited to, x-rays, CT studies, CT angiograms, and any and all other necessary radiographic testing, he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve

repair using an EndoClamp as was performed on December 14, 2011. Had Dr. Harrington performed the proper preoperative testing, he would have determined that the elective mitral valve repair was not necessary at that time and would have aborted the procedure and/or would have used a different technique aside from the use of an EndoClamp. Had Dr. Harrington declined to perform this elective mitral valve repair and/or refrained from using the EndoClamp, thrombus, clot or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this Notice.

Had Dr. Harrington followed the standard of care and properly monitored and observed the intraoperative transesophageal echocardiogram (TEE), he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the procedure and/or used a different technique aside from the EndoClamp approach. Had Dr. Harrington declined to perform this elective mitral valve repair at this point and/or refrained from using the EndoClamp, thrombus, clot, or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this notice.

Had Dr. Harrington followed the standard of care and used the care and technique of a reasonable surgeon in performing the DaVinci mitral valve repair surgery, he would have avoided disrupting any calcium, thrombus or other build-up in the arterial tree during the operation and he would have avoided causing the above referenced injuries and damages to Mr. Kostadinovski. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the surgery and/or used a different approach and/or surgical technique while performing the December 14, 2011 DaVinci mitral valve repair surgery. Had Dr. Harrington maintained the standard of care in this respect, thrombus, clot or calcification would not have broken loose or formed, causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this Notice.

Mrs. Kostadinovski, as the legal wife of Mr. Kostadinovski, is entitled to loss of consortium damages, which are the direct and proximate result of the damages and injuries described above caused by Dr. Harrington. Mr. Kostadinovski along with his wife, are entitled to damages as are deemed fair and just, including, but not limited to the following: reasonable compensation for the pain and suffering incurred by Mr. Kostadinovski, economic loss, emotional damage, loss of consortium, all medical expenses incurred along with a loss of economic opportunity and all other damages and injuries listed previously within this Notice. All rights to any additional and unmentioned damages are hereby preserved.

Had Dr. Harrington followed the standard of care in all respects as outlined above, Mr. Kostadinovski would not have suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain-suffering, loss of ability to perform all activities of daily living, as well as all damages and injuries previously noted within this Notice.

F. THE NAMES OF OTHER HEALTH PROFESSIONALS, ENTITIES AND FACILITIES NOTIFIED:

None other than those noted above.

TO THOSE RECEIVING NOTICE: YOU SHOULD FURNISH THIS NOTICE TO ANY PERSON, ENTITY OR FACILITY, NOT SPECIFICALLY NAMED HEREIN, THAT YOU REASONABLY BELIEVE MIGHT BE ENCOMPASSED IN THIS CLAIM.

MORGAN & MEYERS, PLC

BY _____

JEFFREY T. MEYERS (P34348)
TIMOTHY M. TAKALA (P72138)
Attorneys for Claimant
3200 Greenfield, Suite 260
Dearborn, Michigan 48120-1802
(313) 961-0130

DATED: December 9, 2013

Drago Kostadinovski,

Claimant,

vs.

Henry Ford Macomb Hospital;
Steven D. Harrington, M.D.; and
Advanced Cardiothoracic Surgeons, PLLC,

Respondents.

PROOF OF MAILING

State of Michigan)
)SS.
County of Wayne)

Timothy M. Takala, being first duly sworn, deposes and says that he is employed with the law firm of MORGAN & MEYERS, PLC, and that on December 9, 2013, he caused to be served a copy of M.C.L. 600.2912(b) Notice of Intent to File Claim, upon the following last known addresses:

Henry Ford Macomb Hospital
Resident Agent: Edith L. Eisenmann
Governance Office
1 Ford Place, 5B
Detroit, MI 48202

Henry Ford Macomb Hospital
Resident Agent: Edith L. Eisenmann
15885 19 Mile Road
Mt. Clemens, MI 48043

Steven D. Harrington, M.D.
Advanced Cardiothoracic Surgeons
38800 Garfield
Clinton Township, MI 48038

Advanced Cardiothoracic Surgeons, PLLC
Registered Agent: Steven D. Harrington
49474 Compass Pte
New Baltimore, MI 48047

Steven D. Harrington, M.D.
49474 Compass Pte
New Baltimore, MI 48047

by enclosing same in a well-sealed envelope properly addressed as indicated above by regular first class mail and certified mail, return receipt requested, and deposited in a

United States Mail Receptacle in the City of Dearborn, State of Michigan.

Further, deponent sayeth not.

Timothy M. Takala

Subscribed and sworn to before me this
9th day of December, 2013

Paula Derrick

Notary Public, Wayne County
My Commission Expires: 06/12/2017
Acting in County of Wayne

PAULA DERRICK
NOTARY PUBLIC, STATE OF MI
COUNTY OF WAYNE
MY COMMISSION EXPIRES Jun 12, 2017
ACTING IN COUNTY OF WAYNE

EXHIBIT 5

KOSTADINOVSKI, ET AL. v. HARRINGTON, M.D., ET AL.

EDGAR CHEDRAWY, M.D.

January 22, 2016

Prepared for you by

BIENENSTOCK
NATIONWIDE COURT REPORTING & VIDEO

Bingham Farms/Southfield • Grand Rapids
Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI AND)
BLAGA KOSTADINOVSKI, AS)
HUSBAND AND WIFE,)
Plaintiffs,)
vs.) No. 14-2247-NH
STEVEN D. HARRINGTON,)
M.D., AND ADVANCED)
CARDIOTHORACIC SURGEONS,)
P.L.L.C.,)
Defendants.)

The discovery deposition of EDGAR CHEDRAWY, M.D., taken in the above-entitled cause, before Kyla Elliott, a Certified Shorthand Reporter of the State of Illinois, on the 22nd day of January, 2016, at 4646 Marine Drive, Suite 7C, Chicago, Illinois, pursuant to Notice at 3:55 p.m.

Reported by: Kyla Elliott, CSR
License No: 084-004264

APPEARANCES:

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Representing the Plaintiffs;

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mthomas@rmrtt.com
Representing the Defendants.

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EXHIBITS

(Whereupon, Deposition Exhibit Nos. 1-6 were marked for identification.)
(Whereupon, the witness was duly sworn.)

MR. THOMAS: Let the record reflect that this is the discovery deposition of Edward Chedrawy --

THE WITNESS: Chedrawy.

MR. THOMAS: -- Chedrawy taken pursuant to Notice and upon agreement of counsel and will be used for impeachment purposes only at the time of trial.

Doctor, my name is Matt Thomas. I introduced myself to you before we got started today. I represent Dr. Harrington in a lawsuit that has been filed by the Kostadinovski family.

It's my understanding that you've agreed to act as an expert witness on behalf of the plaintiff in this case; is that fair?

THE WITNESS: That's fair.

MR. THOMAS: Have you had your deposition taken before?

THE WITNESS: With regards to this case?

MR. THOMAS: Not with regards to this case. With regards to other cases.

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THE WITNESS: Yes.
MR. THOMAS: Approximately how many occasions?
THE WITNESS: I believe three times as an expert for defense and four times for plaintiff.
MR. THOMAS: Okay. So you've done about seven expert reviews outside of this --
THE WITNESS: Yes.
MR. THOMAS: Have you been deposed as a witness, either as a fact witness or a named party in any lawsuits?
THE WITNESS: No.
MR. THOMAS: The only rule I'm going to ask you to follow, because you have done this before, is please allow me to finish my question before you begin to answer, even though you might know what my question is before it's out of my mouth. And I'm going to extend the same courtesy to you; I will let you finish your answer. If I do interrupt, please tell me I interrupted you. And I don't mean to do so.
Okay?
THE WITNESS: Okay.
MR. THOMAS: And oftentimes when I ask a question, while it's real clear to me in my head, not so clear when it comes out of my mouth. If you

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don't understand a question or you need clarification, just tell me.
Okay?
THE WITNESS: Sure.
EDGAR CHEDRAWY, M.D.,
called as a witness herein, having been first duly sworn, was examined and testified as follows:
EXAMINATION
BY MR. THOMAS:
Q. Doctor, what's your profession?
A. I'm a cardiovascular and thoracic surgeon.
Q. And we're here today at your office located at Weiss Hospital?
A. Yes.
Q. I'm going to show you what was previously provided to me by counsel, a CV that I've premarked as Exhibit No. 1. Is that relatively up to date and current?
A. I presume so.
Q. Okay. Very good.
And just to go through it very, very briefly, Doctor, you did your medical education in Canada, correct?
A. Yes.
Q. You're originally from Canada?

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A. Yes.
Q. And thereafter you did a residency in cardiac surgery in Canada?
A. Yes.
Q. And I know that was followed by a cardiopulmonary implant fellowship at Stanford, correct?
A. Transplant fellowship.
Q. And I know you're board certified in cardiac surgery through the Royal College of Surgeons in Canada, correct?
A. Yes.
Q. Have you ever sat for any of the boards either by the American Board of Surgery, the American Board of Thoracic Surgery?
A. No.
Q. You did not perform a general surgery residency?
A. No.
Q. You did not perform a cardiovascular and thoracic surgery residency?
A. I don't understand that question.
Q. Sure.
Your -- the residency that you completed was -- the title was cardiac surgery?

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A. Integrated residency in cardiac surgery, yes.
Q. Does that incorporates thoracic surgery as well?
A. Yes.
Q. You're not board certified by the American Board of Thoracic Surgery, correct?
A. No.
Q. There's a number of publications and presentations in that CV that we've marked as Exhibit No. 1. Do any of your publications or presentations touch on the issues in this case, as you see them?
A. I've presented many times on aortic surgery that involves surgery of the thoracic aorta, the ascending aortic arch and the descending aorta which will probably pertain to the issues in this case.
Q. Any presentations or publications on robotic-assisted mitral valve repairs?
A. Not on robotic per se but on minimally invasive valve surgery, yes.
Q. And maybe we'll come back to it once we get some of your opinions as to whether or not there's anything in your CV that you believe would

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be informative as to your opinions or that would support your opinions. But let me just ask you briefly, we're here at Weiss Hospital.

I know from your CV you're on staff at a number of Chicago area hospitals, correct?

A. Yes.

Q. Do you currently hold any type of academic appointments?

A. I'm an associate professor of surgery at the University of Illinois in Chicago.

Q. And do you hold any administrative appointments here at Weiss Hospital or any of the other --

A. I'm the medical director for the cardiovascular and thoracic surgery at Weiss Hospital. I also serve as the vice chair of the Department of Surgery for quality and education.

Q. And all of that's contained in your CV, correct?

A. I believe so, yes.

Q. Your -- I presume your license has never been subject to any type of disciplinary --

A. Never.

Q. And I saw at one point you were licensed in California. Was that when you were doing your

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fellowship --

A. Yes. I was a heart and lung transplant fellow at Stanford for a year.

Q. Let me make sure I get my question out. I know -- we're starting to talk over -- and it's going to make Kyla's job a little bit more difficult.

Credentials ever been curtailed in any way?

A. No.

Q. Let me ask you a little bit. You told me you've performed seven prior reviews. And were those medical malpractice cases?

A. Yes.

Q. And I think you said -- was it four on behalf of defense?

A. If I remember correctly, I think four for the plaintiff and three for the defendant.

Q. The defense cases, were those in the State of Illinois or were those outside the state?

A. I think they've all been outside of the state, actually.

Q. Have you been asked to review any cases in the State of Michigan in the past, outside of this case?

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A. Yes.

Q. Do you remember for whom you were -- strike that.

Do you remember by whom you were retained in those cases?

A. I believe one was with Mr. Meyers, one was with another attorney -- I think the last name was Garvey.

Q. Bob Garvey, does that sound right?

A. I think so. I can't remember the exact. And I believe there was a third case. But I can't remember the actual name.

Q. And those -- did any of those prior seven cases go to trial?

A. No.

Q. You gave depositions in those seven. Do you know how many cases in total you've reviewed as an expert witness?

A. Over the last 12 years?

Q. Correct.

A. I suspect over 25 to 30 cases.

Q. Okay. And could you give me a percentage breakdown as to what percentage of those 25 to 30 cases that you've reviewed in total were for plaintiff versus defense?

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A. I'd probably be guessing. I'd say about two-thirds for plaintiff, one-third for defense.

Q. The case that you reviewed for Mr. Garvey, if that was, in fact, his name, if you're remembering correctly, do you remember who the defendant was in that case?

A. No. No.

Q. In that case were you -- did you have an opinion that a Michigan surgeon had committed malpractice or was negligent?

A. No.

Q. And the other case that you were reviewing for Mr. Meyers, is that case concluded or is it still going on, if you know?

A. It's concluded.

Q. In that case did you offer an opinion that a surgeon had committed malpractice or was not negligent?

A. I believe he was not negligent.

Q. Did you give a dep in either of those cases?

A. I don't think so, no.

Q. Do you know if you signed an affidavit of merit? And I'll show you what we previously marked as Exhibit 2. Do you recall executing that

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affidavit?
A. Yes.
Q. In any other case -- strike that.
Have you authored or executed something similar for any other Michigan cases that you're aware of?
A. If I remember correctly, I think once I have.
Q. And do you remember who the attorney was on that case?
A. I can't remember.
Q. You were kind enough -- Mr. Meyers was kind enough as well to let me take a peek at your materials before we got started here. Is everything that you have as part of your file here on this circular table?
A. Yes.
Q. And just very briefly, you reviewed the deposition of Lynn Masinick, the perfusionist?
A. Yes.
Q. And then both volumes of Dr. Harrington's deposition, correct?
A. I only had Volume 1, volume 2 I literally just downloaded and printed out probably 45 minutes ago.

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Q. Have you had a chance to take a look at it at all?
A. Not really.
Q. There's your affidavit that we marked as Exhibit No. 2. You have a copy of that?
A. Yes.
Q. And then you have various medical records from Henry Ford Macomb Hospital. And you reviewed all of those records that you were provided, correct?
A. Yes.
Q. Were you provided Dr. Harrington's office chart as well?
A. I don't believe so.
Q. You also have my notice of taking deposition today?
A. Yes.
Q. And, I apologize, there's some e-mails that reference your invoices, correct?
A. Yes.
Q. And those were just to Mr. Meyers' office?
A. Yes.
Q. And the notice of intent to file a claim that was filed in this case, correct?
A. Yes.

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Q. And that's something you reviewed.
And then there were three articles. And I've marked those three articles that were in your file as Exhibits 3, 4 and 5.
A. Yes.
Q. Were those articles that you pulled up or were those articles provided to you?
A. These articles I pulled up.
Q. Okay. Thank you. And we'll talk about those in one second.
And then, lastly, I marked as Exhibit 6 a -- and it's on the back of some correspondence. But I'm only concerned about the handwritten side. Those are your time records?
A. Yes.
Q. Do you know how much you've billed in this case so far?
A. I think I added them up before we met today. It was a total of 19 hours.
Q. 19 hours. And what is your rate for review?
A. I believe it was $450 per hour for review and discussion.
Q. So 450 times 19. And then you have a separate charge for deposition time, correct?

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A. Yes.
Q. And what is your deposition fee?
A. If I remember correctly, it was 550.
Q. 550 an hour?
A. Yes.
Q. And I wasn't clear if you recalled seeing my check. I was told at my office we had already mailed your check. Do you remember receiving that?
A. I received it, yes.
Q. And did we pay you for two hours?
A. I believe it was two hours. I haven't cashed it yet.
Q. That's okay. Well, if there's more -- I don't suspect there will be -- but you can let me know.
And then do you have a separate charge for trial testimony?
A. I've actually never been to a trial. So I'm not sure how that would work.
Q. If this case were to go to trial, are you willing to come in and testify live?
A. Yes.
Q. Other than the affidavit of merit that we marked as Exhibit 2 in this case, have you authored any written reports or anything like that in this

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case?
A. No.
Q. Do you know my client, Dr. Harrington?
A. No.
Q. One of -- and I didn't see it in your file materials. The affidavit of merit that you signed in this case, Exhibit 2, by law in Michigan, I have to assume that an affidavit of meritorious defense -- in this case Dr. J. Michael Smith out of Ohio signed our affidavit.
Are you familiar with Dr. Smith?
A. No.
Q. Have you ever seen him present on any of the robotic-assisted mitral valve replacement, if you know?
A. Not that I'm aware of, no.
Q. I notice that on your CV that you're a member of the American Society of Thoracic Surgeons?
A. Yes. Society of Thoracic Surgeons.
Q. Thank you. I messed up the name.
Did you happen to -- have you ever -- strike that.
Do you know if you attended the robotic -- the talk on robotic-assisted mitral valve

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replacement in 2012 at the national meeting?
A. I can't remember if I went to the meeting in 2012.
Q. Okay. Thank you.
Any of those cases that you've reviewed as an expert witness, did any of those involve mitral valve replacements?
A. Yes.
Q. Any of those -- out of those cases, any of those, was the technique robotic-assisted?
A. Yes.
Q. In those cases were you -- do you know how many there were?
A. If I remember correctly, two.
Q. So two prior to this case here?
A. Yes.
Q. And in those cases were you acting as an expert for the plaintiff or for the defense?
A. One for the plaintiff, one for the defense.
Q. Do you remember the name of those cases?
A. I remember one was out of Utah where I acted as the witness for the defense. And the second case I can't remember which state it was out of. I can't remember the name.

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Q. Do you remember the name of the attorney in Utah that you were retained by?
A. Not at this moment, no.
Q. If it comes to you, will you let me know?
A. I'll let you know, yeah.
Q. I want to talk a little bit about your -- back up before I do that.
I think you indicated that you've never testified as a named party in a lawsuit. Have you ever been named as a defendant in any type of medical malpractice claim or notice?
A. I've been named once in 2006.
Q. Was that involving a mitral valve repair, if you know?
A. It was a potential mitral valve repair case, yes.
Q. So it didn't have anything to do with your -- do you just generally remember what the allegation was in that case?
A. Yes. It was a young patient that needed a mitral valve repair. I recommended a repair to the patient. The patient and his cardiologist decided they did not want to repair.
And the patient was sent home. He died a month later. I was named as a co-defendant. It

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was quickly dropped. I think I was a respondent in discovery, I think I was labeled as that. But it was not an operative case.
Q. Describe for me, if you will, your clinical practice.
A. Sure. I practice all aspects of adult cardiovascular and thoracic surgery, so focusing mostly on coronary valves, aortic aneurysms and dissections; on the thoracic side, lung cancer cases, video-assisted thoracoscopy. So open end and minimally invasive cases.
Q. Do you have a breakdown or are you able to breakdown the percentage of thoracic versus your cardiovascular practice?
A. I'd probably say cardiovascular is about 60 percent and thoracic is about 40.
Q. And out of that 60 percent, how much of your practice is devoted to mitral valve repair, either stand-alone or in conjunction with bypass or something like that?
A. You know, valve cases are almost about 40 to 50 percent of the practice.
Q. Now, do you -- out of those 40 -- strike that.
Out of those cases that you do the mitral

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valve cases, the -- let's focus on the stand-alone, just valve repair, they're not in conjunction with some other type of cardiovascular surgery -- do you do -- you do minimally invasive approach, I assume?

A. Yes.

Q. Do you do the general -- like the open thoracotomy approach? I call it the standard approach. But I guess it might not be standard --

A. The open sternotomy.

Q. Sternotomy. Excuse me. That's what I meant.

A. Yes. I'm sorry.

Q. No. You're fine. I appreciate the correction.

What percentage are you doing the sternotomy versus some sort of minimally invasive approach?

A. The minis for me are a smaller part of my practice.

Q. Now, do you do the robotic-assisted mitral valve repair such as was done with Mr. Kostadinovski?

A. Using the actual robot for the repair, no.

Q. So when we're -- with your minimally invasive -- what's the difference between your

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minimally invasive practice versus utilizing the actual robot, like was used in this case?

A. Sure. With regards to the word minimally invasive for cardiac valve repair and replacement, we're mostly referring to the size of the incision. They all involve cardiopulmonary bypass. What really differs is the approach -- the surgical approach, whether it's through an open sternotomy or through a small thoracotomy or a hemisternotomy. I'll use the smaller incisions but use longer endoscopic instruments as opposed to using the robot.

Q. I did see on your CV that we marked as Exhibit 1, you've gone through the da Vinci training?

A. Yes.

Q. But it is not something that you utilize in your practice?

A. Not often, no.

Q. Well, not often. Are you using it for a portion of your practice?

A. I use it mostly on the thoracic side, if needed. But most of the cases I'll still do thorascopic or minimally invasive, but minus the robot.

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Q. Do they have the robot here, at Weiss?

A. Yes.

Q. How much time do you spend -- strike that.

What percentage of your surgeries are performed here, at Weiss?

A. Probable 30 percent at Weiss.

Q. You're also at Swedish Covenant?

A. Swedish Covenant is where my main office is, yes.

Q. And how many -- what percentage of your procedures are done --

A. Probably 40 to 50 percent.

Q. How about the remaining?

A. Probably the remaining 10 to 20 percent with other hospitals we cover, Thorek Memorial Hospital where we cover call.

Q. So Weiss has the da Vinci robot. Does Swedish Covenant have the da Vinci --

A. Yes.

Q. -- robot as well?

A. So does Thorek.

Q. Are you a member or are you employed by a group or are you employed by the hospital?

A. I'm employed by Swedish Covenant Medical Group.

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Q. And here at -- does your group -- Swedish Covenant Medical Group, do they also supply other cardiovascular surgeons, cardiothoracic surgeons here at Weiss?

A. Yes.

Q. Do you have somebody in your group, in your practice that, for lack of a better term, is the guy who uses the robot for mitral valve repairs?

A. No. Mostly I do most of the cases that are minimally invasive.

Q. Forgive me for -- I think I may have asked you this. Have you used -- although it's not a part of your general practice for valve repair, have you used the da Vinci robot for that procedure?

A. No.

Q. Do you utilize an EndoClamp?

A. Yes.

Q. Do you utilize an EndoClamp in mitral valve repair?

A. Yes.

Q. Do you always use an EndoClamp for minimally invasive mitral valve repair?

A. Yes.

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Q. I know we've marked your affidavit. And we'll come to it in a moment. But I just want to talk in general in this case. You've had a chance to review at least a portion of Dr. Harrington's deposition, at least Volume 1 --

A. Yes.

Q. -- and the records. And I -- so you've received the information that you didn't necessarily have when you -- when you initially signed this affidavit, correct?

A. Correct.

Q. And I want to ask you, just generally speaking, what your opinions are. And while you may have lots of opinions, and we all have lots of opinions, I'm very interested in what opinions you hold that rise to the level of a violation of the standard of care.

And when I talk about the standard of care, you have an understanding of what I'm talking about?

A. Yes.

Q. So is it fair to say that you believe Dr. Harrington violated the standard of care in some respect? I would assume the only reason I'm here is because you have that opinion?

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A. Sure.

Q. Could you tell me, if you would, which actions or omissions, whatever the case may be, you believe rise to the level of a violation of the standard of care by my client, Dr. Harrington.

A. Upon reviewing the information I had available for the case and understanding the approach he used for the procedure and the ensuing events with regards to the stroke, the question I really had was with regards to the use of the EndoClamp, whether a proper preoperative assessment was done for the aorta.

Upon reviewing the perfusionist's record which became available to me, I guess a month or so ago, there was a question of letting the hemoglobin drop or drop down to a certain level that was not corrected immediately.

Q. Well, let's start with the utilization of the EndoClamp and whether the appropriate preoperative assessment of the aorta was done. Is it your opinion that there was a failure by Dr. Harrington within the standard of care to do -- strike that. Let me start over.

Is it your opinion that Dr. Harrington violated the standard of care in failing to do an appropriate preoperative assessment of the aorta, given that he utilized an EndoClamp in his December 2011 surgery?

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A. Yes.

Q. Why don't you tell me what you believe the standard of care required with respect to the use of an EndoClamp.

A. The way an EndoClamp is used involves a clamping device within the aorta to cause an occlusion or lack of flow across that area. So to do that safely, we need to assess the aorta to make sure there's no atheroma that may dislodge upon deployment or redeployment of the clamp.

Q. And what assessment -- preoperative assessment was required by the standard of care?

A. My assessment would include a CT angiogram to formally evaluate the aorta.

Q. And with all due respect, Doctor, in Michigan we have a law that what you do is not necessarily what is at issue, it's what the standard of care, meaning what the average, reasonable, prudent, similarly qualified, in this case, cardiothoracic surgeon would have done under the same or similar circumstances. You indicated that you do a CT angiogram to formally evaluate the aorta.

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Do you believe that the standard of care, meaning the average, reasonable, prudent cardiothoracic surgeon -- not the best, not the worse, somebody who's just reasonable and prudent -- was required or also does CT angiograms to formally evaluate the aorta?

A. I guess now I understand your question a little better. I guess to clarify, in 2011, that may not have been considered the standard of care. But, nowadays, I believe it would be the standard of care. Yes.

Q. And we all know that medicine is very dynamic and it's fluid, correct?

A. Correct.

Q. And it changes, it seems almost daily, but certainly by year, correct?

A. Yes.

Q. And the standard of care has changed, correct?

A. I believe so.

Q. So -- and just so if I can paraphrase, and you tell me if I'm wrong, it's your opinion that while now you believe that the standard of care formally does require a CT angiogram to evaluate

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the aorta prior to utilizing an EndoClamp; in 2011, you're not -- you don't believe you can say that the standard of care required Dr. Harrington to do a preoperative CT angiogram; is that fair?

A. That is fair.

Q. Good news is it cuts a bunch of my questions.

I want to talk about the hemoglobin and the hematocrit for a moment.

A. Yes.

MR. THOMAS: And this doesn't involve you. And Mr. Meyers knows I have to place this on the record. And just to the extent that there is an assertion that there was a violation by Dr. Harrington to transfuse the patient during the surgery at issue, I would just object. And I would move to strike that allegation as it wasn't pled in your notice of intent nor the doctor's affidavit of merit.

MR. MEYERS: And I'll make my mini record. And that is, before the deposition of the transfusion, I, in fact, notified counsel of this potential issue so that we would not be accused of hiding the issue or sandbagging, whatever term of art one might want to use. And in advance of this

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deposition, I put both Mr. Manion and Mr. Thomas on notice of this as a potential issue so that there would be no question with regard to surprise or prejudice.

MR. THOMAS: And I do agree that I did receive a call from Mr. Meyers. And he did indicate that this was coming.

BY MR. THOMAS:

Q. So with that, let's talk about your opinions.

When you were -- and I didn't notice, Doctor. In the records that you reviewed -- first of all, there's some highlights on these records. Are these highlights yours --

A. Yes.

Q. -- or were they sent to you like this?

A. No. They're my highlights.

Q. I also noticed in some of the depositions there are some dog-eared pages and I think some highlights as well. Are those your dog-ears and/or highlights?

A. Yes.

Q. Do you recall whether you were provided with a copy of the perfusion record --

A. Yes.

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Q. -- in this case? Okay.

MR. THOMAS: I'm going to try to be quick. You may know where it is. I mean, it's --

MR. MEYERS: What are you looking for, Matt?

MR. THOMAS: Perfusionist's chart.

MR. MEYERS: It's in the exhibit --

MR. THOMAS: One of these -- and let me clarify -- if you don't mind getting that out, Jeff, just for the doctor. And I understand that the perfusion record was made part of an exhibit. And it may have even been a part of Dr. Harrington's exhibit as well, but certainly Lynn Masinick, when she was deposed.

Thank you.

BY MR. THOMAS:

Q. Had you seen this -- and what I'm referring to is Exhibit 2 to Lynn Masinick's deposition -- the cardiopulmonary bypass record prior to receiving her deposition?

A. No. I received it as part of her deposition.

Q. Okay. Had you reviewed the blood gases or blood draws that were -- strike that.

As part of your initial review, when you executed the affidavit of merit in this case, did

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you review the blood gases and blood draws that were performed during the surgery?

A. I don't believe I had access to them.

Q. Okay. Did you see the anesthesiology record in this case?

A. I think I saw the anesthesiologist record.

Q. Okay. Did you take note on that record that there was some documentation of the levels of hemoglobin, the hematocrit, the pH, the PC02; those type of things?

A. If I remember correctly, it was very hard to decipher.

Q. Fair enough.

So why don't you tell me, just generally speaking, what your criticism is with respect to the management of the patient while she was on bypass.

A. Well, he was on bypass.

Q. He. Did I say she? I apologize. He.

A. While he was on bypass, and after reading the deposition of the perfusionist, there was some concern raised about the perfusionist, about the blood level, the hemoglobin level. So that drew my attention to looking at the page 1859 of Exhibit 2.

Q. And what you're referring to is Exhibit 2

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to Ms. Masinick's deposition. I don't remember if there's -- the whole record I think is four pages, but there might only be three as part of Exhibit 2. Could you just tell me how many pages there are to that record -- or to that exhibit, excuse me. Excuse me, you know what, I think you missed one. You know what, I forget Mr. Meyers is good at marking them separately. So there's two. And I think there was -- so there were three pages marked of that record. And that's Exhibit 2, Exhibit 3 and Exhibit 4 to Ms. Masinick's deposition.

What -- just so we're looking at the same thing.

MR. THOMAS: Thank you.

BY MR. THOMAS:

Q. What particularly on Exhibit 2 causes you concern?

A. At 11:24 the hemoglobin level is 5.1, the hematocrit of 15.

Q. Anything else that you see that is concerning at 11:24 on the values that are documented there?

A. Not that I can point at right now, no.

Q. And then the next -- and if you recall from Ms. Masinick's deposition, when she received

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that -- those values back, she did a redraw, correct?

A. I believe so, yes.

Q. Okay. And when the redraw came back, the hemoglobin, I forget, it was 11:30 -- do you have the time there?

A. At 11:32 the hemoglobin was 5.1 with the hematocrit of 15.

Q. So the levels were the same?

A. Yes.

Q. Do you recall what Ms. Masinick's testimony was with respect to her -- what she did to address the hemoglobin and the hematocrit in that case?

A. If I remember correctly, she reported it to the surgeon.

Q. Did she take any corrective action?

A. I would have to go back and review her deposition. I don't remember.

Q. Now, Doctor, you remember -- actually you might not remember Dr. Harrington -- because you didn't read Volume 2 of his deposition?

A. I only received it an hour before --

Q. Understood. And I'm not faulting you. I'm just suggesting that you haven't -- you didn't

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have a chance to look at that.

Do you remember Dr. Harrington -- and, quite frankly, I don't remember if it was in Volume 1 or Volume 2 -- being asked any questions about the hemoglobin or hematocrit by Mr. Meyers?

MR. MEYERS: It's in Volume 2. And we went over those pages. But I think it's in the page 54 range, if you're looking.

MR. THOMAS: That's fine.

BY MR. THOMAS:

Q. And you remember Dr. Harrington then, it sounds like you went over those pages. Dr. Harrington indicated to Mr. Meyers, in response to his questioning, that he would expect to be notified of that, correct?

A. Yes.

Q. Because he would also find that to be concerning, correct?

A. Yes.

Q. And that -- and what is it that you believe Dr. Harrington should -- and let's presume -- for purposes of this question only, let's presume that Ms. Masinick did, in fact, tell Dr. Harrington that the hemoglobin was 5.1 and the hematocrit was down to 15. What would you expect

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Dr. -- what did the standard of care require Dr. Harrington to do?

A. At a hemoglobin of 5.1 on cardiopulmonary bypass, I would transfuse the patient. I believe that's what the standard of care would be.

Q. And, again, you used the word, I would have transfused the patient. And I just want to -- and then I think you followed it up. But I just want to make sure.

So do you believe that the standard of care -- again, going back to what the reasonable and prudent, similarly qualified surgeon under the same or similar circumstances in December of 2011 -- would that standard of care require transfusion based on these numbers?

A. Yes.

Q. One second. Is there -- and while I'm looking at that, is there anything else that you believe the standard of care required Dr. Harrington to do in response to this hemoglobin and hematocrit values at 11:24 and again at 11:32?

A. Other than transfuse the patient?

Q. Right.

A. Ideally hemoconcentrate, make sure the oxygen saturations are in the level we want them to

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be and make sure the pressure -- perfusion pressure of the patient is adequate.

Q. Were the oxygen saturation levels okay -- strike that.

I asked you before, did you see anything else in those values that you found to be concerning beyond the hemoglobin and hematocrit. And I believe you indicated that you did not. Do you see anything -- any problems with the oxygen saturation level as they are documented there?

A. At 11:51 the hematocrit is still 5.1, the oxygen saturation is 75.

Q. What could account for that decrease in oxygenation at that point, if you know?

A. It's hard for me to decipher from the record.

Q. Are there certain possibilities that you, as a surgeon, would -- could correlate to those numbers?

A. I don't understand your question.

Q. Sure. Let me see if I can clarify.

As a surgeon -- and understanding you're looking at somebody else's record, but taking into account your experience, maybe not this patient, some other patient -- if you saw an oxygen

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saturation level drop down to -- I believe you said 72?

A. 75.

Q. 75 -- excuse me -- what types of things could cause that?

A. I would ask the perfusionist why they thought the oxygen level was low, if there was any problems with their oxygenator, and hopefully address them.

Q. And now at -- nine minutes later, their oxygen saturation level is right back up to 100, correct?

A. Yes.

Q. And I'm not very good at math, so 11 -- 19 minutes earlier, at 11:32, which was the previous value, it was at 100 percent, correct?

A. Yes.

Q. Is it possible that 75 is just an anomaly or not an accurate reading?

MR. MEYERS: Form.

THE WITNESS: Could be.

BY MR. THOMAS:

Q. Now, the other thing you said was ideally there would be some -- you would hemoconcentrate, you would check the oxygen saturation levels. You

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mentioned one other thing?

A. Perfusion pressure.

Q. And is the perfusion pressure documented on this chart?

A. They have a column at the top that says MAP, mean arterial pressure.

Q. And if we look at the mean arterial pressure, it looks like 11:30, I see 55; 11:45, it's 69 I'm guessing. I could be wrong. You might read it differently. 12:00, 64; 12:15, 63; 12:30, 65; 12 -- whatever that next number is -- 73. Anything concerning about those mean arterial pressures that would suggest to you a problem?

A. No. They seem adequate.

Q. Ms. Masinick was asked in her deposition whether or not she took any type of corrective action for the hematocrit and hemoglobin findings at 11:24. And she talked about aggressively hemoconcentrate by applying a vacuum.

Do you understand what that means?

A. I presume she's getting at eliminating any hemodilution to help hemoconcentrate the blood; in other words, removing fluid and keeping hemoglobin

Q. And she said she -- and maybe I didn't read this appropriately -- aggressively

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hemoconcentrated by applying vacuum to my hemoconcentrator which is indicated on line 11:30.

Did you see that she took that corrective action in the chart, or does that help you understand the chart a little bit better?

A. If I'm reading the third line on the top half, it looks like it says -- scribbles hemoconcentrate and then there's an arrow and then something else I can't read.

Q. Yeah.

A. I presume that's when she started the hemoconcentrate.

Q. She said, status, hemoconcentrator, arrow pointing, meaning vacuum and then vacuum applied.

And did that -- was that an appropriate measure or an appropriate response to a decrease in hemoglobin and hematocrit?

A. Yes.

Q. And the hemoglobin and hematocrit does respond and comes back up, does it not?

A. If that maneuver was started at 11:30, yes, by, I presume 12:00 o'clock, if I'm reading that number correctly, we do see the hematocrit go from 15 to 21 and the hemoglobin go from 5.1 to 7.1.

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Q. So if we presume that between 11:24 and noon are 36 minutes, correct?
A. Yes.
Q. Is that response time adequate when you see a decreased hemoglobin and hematocrit?
A. No.
Q. So it's still your opinion that at some point Dr. Harrington should have ordered a transfusion to assist in bringing those levels up; is that correct?
A. Yes.
Q. Am I understanding you correct?
MR. MEYERS: Asked and answered. He said 11:24.
MR. THOMAS: Didn't I say --
MR. MEYERS: You said at some time. I'm sorry.
BY MR. THOMAS:
Q. I apologize. Let me clarify.
It's your opinion that the standard of care required that transfusion at -- when he would have been notified of those levels at 11:24 or shortly thereafter?
A. Yes. As per the record, 11:24, so he was notified of the hemoglobin at 5 --
Q. And it doesn't say that Dr. Harrington was

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notified of the hematocrit and hemoglobin in the record, that's based on Ms. Masinick's testimony, that she would have notified him, correct?
A. My understanding, from the testimony, is that she notified him, yes.
Q. Now, crystalloid is -- can be a volume replacement, correct?
A. Yes.
Q. And I know there was some discussion with Ms. Masinick about crystalloid being given post-bypass, correct? Do you remember that testimony?
A. Not specifically.
Q. I don't know if you have handy the -- strike that.
While I'm looking for it, do you -- would crystalloid be an appropriate tool to use in response to a decrease in hemoglobin and hematocrit along with the hemoconcentrator?
A. No.
Q. So whether or not crystalloid was given during bypass, that doesn't affect your opinion at all?
A. Well, the purpose of hemoconcentration is to remove fluid. By giving crystalloid you're

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actually doing the opposite, you're hemodiluting a patient.
Q. Did you see anything in that record -- that record, the perfusion record, Exhibit 2 for Ms. Masinick's dep, that suggests malperfusion besides the decrease in the hemoglobin and hematocrit?
A. I don't quite understand your question.
Q. Sure. What is the concern -- well, let me do it this way.
What is the concern or what is your concern that there was a decrease in hemoglobin and hematocrit? What does that mean for the patient?
A. The decrease in hemoglobin will reduce the oxygen carrying capacity of the blood which means less oxygen is delivered to the end organs which will result in ischemia at some level.
Q. And where would you typically, as a surgeon or would you be concerned as a surgeon, to see that ischemia first?
A. The most sensitive organ to ischemia is usually the brain.
Q. Okay. So in this case is it just a dilution effect as a result of -- and maybe I'm not saying it right. Because you're having a decrease

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in hemoglobin and hematocrit, do you believe there was a -- that the patient was volume depleted or had low flow or do you believe it was because the patient was -- blood was diluted?
A. The hemoglobin measures the amount of packed red blood cells.
Q. Right.
A. It's circulated. When you give crystalloid, you'll hemodilute those packed red blood cells. And then the hemoglobin level would go down. If your question, if I understand it correctly, is looking at what the main concern was, they're different concepts, oxygen saturation versus anemia versus pressure. They're -- there's three different concepts that all have the same end goal which is to provide oxygen to the tissue.
MR. MEYERS: His question really, I think --
MR. THOMAS: Please.
MR. MEYERS: -- was, do you have an opinion as to why the hemoglobin and the hematocrit dropped so precipitously, forgetting the fact that he wasn't transfused? Do you have an opinion as to the why part?
MR. THOMAS: That's probably a better question anyway, Jeff.

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THE WITNESS: The hemoglobin will drop either because we've hemodiluted, by giving too much crystalloid, or there's active blood loss.
BY MR. THOMAS:
Q. Do you have an opinion in this case whether there was actual blood loss or that this was just a hemodilution?
A. I don't have an opinion because I would have to see how much blood came out of the cell saver and the cardiotomy suckers to see how much was actually occluding the circulatory system. And I need to know how much volume the perfusionist gave, crystalloid or colloid.
Q. Okay. And that crystalloid or colloid that we'd be worried about what was being given either before bypass or while the patient was on bypass?
A. Yes. Giving crystalloid or colloid solution would hemodilute the patient, resulting in a low hemoglobin.
Q. Is there a certain standard with respect to how much you give or is it based on other -- the values that you're seeing at that time?
A. Depends on the patient's body weight, their age and their starting hemoglobin.

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Q. In this case do you, as a surgeon -- strike that. Strike that -- strike my preface, in this case.
Do you, as a surgeon, dictate the amount of crystalloid or colloid that is given during -- given to a patient either before bypass or during bypass?
A. We definitely have a say in determining the amount of fluid that's given. We would do that in conjunction with the perfusionist and try and figure what the appropriate level of volume should be.
Q. In this case do you an opinion one way or another what the appropriate level of volume should have been for Mr. Kostadinovski before or during bypass?
A. I don't remember his actual weight or what the cardiopulmonary bypass circuit was primed with.
Q. You have not seen any evidence that there was any type of actual blood loss or excessive blood loss in this case, have you?
A. Not that I remember.
Q. Do you have an opinion in this case as to what caused the stroke?
A. I don't understand -- that's a very general question.

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Q. It is.
Mr. Kostadinovski suffered a stroke, correct?
A. Yes.
Q. Do you believe that stroke was suffered while he was in the operatory with Dr. Harrington?
A. Yes.
Q. Do you have an opinion as to what type of stroke he had?
A. From what -- I have not seen the actual CTs of the head. But from what I understand from the reports, they had mentioned both a possible embolic phenomenon or a watershed phenomenon.
Q. Beyond that do you have an opinion one way or another whether this was an embolic or a watershed phenomenon?
A. As I said, I haven't seen the actual images. So it's hard for me to discern which type.
Q. So the answer is, you can't without actually seeing more information; is that fair?
A. Exactly.
Q. If it was an embolic event, would that be related in any way to a decrease in hemoglobin and/or decrease in hematocrit?

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A. It may not be related, no.
Q. If it was more of a watershed phenomenon that was seen on the films, that's -- would that be related to a decrease in hematocrit and/or a decrease in hemoglobin?
A. It could be, yes.
Q. And that's usually because of some sort of malperfusion or poor perfusion or delivering of oxygen to the brain?
A. Signifies poor oxygen delivery which could be from one of the factors we mentioned such as low perfusion pressure, anemia or low hemoglobin or low oxygen saturation.
Q. And I'm not sure if this is out of your area of expertise, and if it is, you can tell me or if you have an opinion, you can -- that's fine as well.
Do you have an opinion whether or not you can have unilateral watershed phenomenon or is that something typically you would see bilaterally?
A. I think you'd have a bilateral problem, yes.
Q. You agree with me, generally, that there is a stroke risk carried with mitral valve repair, correct?

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A. It's a very general question. I think with -- if I may qualify it. With any cardiopulmonary bypass circuit, there is a possibility of a stroke.

Q. With mitral valve repair, do you -- all comers or all techniques, I should say, do you know what the literature says with respect to a stroke risk?

A. If I remember the STS database correctly, it's probably 1 or 2 percent.

Q. Do you know if there's a higher or a lower stroke risk related to minimally invasive mitral valve repair?

A. It would depend on the technique for minimally invasive.

Q. Let's talk about robotic-assisted mitral valve replacement like was done in this case. Do you have an understanding what the cited stroke risk is with that?

A. I'm not aware of the exact numbers for an EndoClamp versus a transthoracic clamp because even with minimally invasive and robotic-assisted, we can also do a transthoracic clamp.

Q. Do you believe the risk is higher with the EndoClamp?

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A. I don't know the actual numbers.

Q. That's fine. Fair enough.

In this case did -- in any of the records that you reviewed, do you believe Mr. Kostadinovski had any medical history or co-morbidities that put him at an increased risk for stroke?

A. I can't remember his actual co-morbid profile.

Q. Would hypertension put somebody at a higher risk for stroke?

A. Yes.

Q. Would a significant smoking history put somebody at a higher risk for stroke?

A. Yes.

Q. Would diabetes put somebody at a higher risk for stroke?

A. Yes.

Q. And I know you've answered this. But I just want to be clear, so I know what your testimony will be down the road.

Is it your -- you are not going to come in to court at the time of trial and say, this stroke was a result of -- was an embolic event or some sort of watershed phenomenon because you haven't reviewed those films, correct?

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A. I have not reviewed the films.

Q. Do you intend on reviewing those films --

MR. THOMAS: Or, Jeff, are you going to have him review those films?

MR. MEYERS: I will notify you immediately if he will be called in that area. My expectation is that given Dr. Levine's role in the case and Dr. Naidich's, I would expect not.

MR. THOMAS: I presume that as well. But, yeah, if you'd just give me the courtesy of letting me know --

MR. MEYERS: Yes. Of course.

MR. THOMAS: -- and then maybe have a five-minute deposition over the phone.

MR. MEYERS: Yes.

BY MR. THOMAS:

Q. I just want to look at those articles that we marked -- thank you. Article 3 is a review article in the -- entitled robotically-assisted minimally invasive mitral valve surgery.

I was just looking at something that you highlighted. In the highlighted portion on page 5696 of the article -- and it's talking about the CT angiography. And we've covered that opinion and what -- based on what you've told me about that

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earlier, correct?

A. Yes.

Q. Is there anything in this article, Exhibit 3, that relates to the decrease in hematocrit or hemoglobin as you see it?

A. No.

Q. And then Exhibit 4 is an imaging. And, again, it talks about preoperative CT angiography. And that's -- like we said, we've already discussed that, correct?

A. Yes. Exhibits 4 and 5 are the prelude articles to exhibit --

Q. I gotcha. And I noticed that you had highlighted one of the citing -- one or more of the citing articles. So, again, neither exhibit or -- Exhibits 3, 4 or 5, they do not have any information that would -- talks about the decrease in hemoglobin or hematocrit or the need to transfuse or anything like that; is that fair?

A. All three papers relate to preoperative CT angiography. They do not address the issue of the drop in anemia.

Q. Thank you.

And real quick with this. Based on what you already testified to -- but I do have to

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clarify. And you can follow along. I'm looking at what we marked as Exhibit 2 which was your affidavit.

If you look to paragraph 11, there's a number of subparagraphs that follow that, exactly. I just want to clarify -- and this is based on the additional information that we've seen and what you've already told me today. But I want to make sure, you're not -- it's not your testimony that Mr. Kostadinovski was not a -- strike that.

See if I can formulate something that makes sense. It's not your testimony today that --

MR. MEYERS: Can I help for a second?

MR. THOMAS: Yeah.

MR. MEYERS: Have you articulated the opinions regarding the violations of the standard of care that you would expect to offer at the time of trial? So in the deposition so far, in your discussion with Mr. Thomas, have you articulated all of your violations of the standard of care, sir?

THE WITNESS: I believe so.

MR. MEYERS: And they relate solely to the failure to perfuse the patient beginning at 11:24 and continually thereafter?

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THE WITNESS: Yes.

MR. MEYERS: And you have no other violations of the standard of care that you would expect to offer at the time of trial?

THE WITNESS: Not at this moment.

MR. MEYERS: We don't have any expectation to offer any other violations. But we'd notify you immediately if something changes.

MR. THOMAS: Thank you, Jeff.

MR. MEYERS: Okay. We're off the record.

(Whereupon, a discussion was had off the record.)

BY MR. THOMAS:

Q. One last question for you, Doctor.

A. Yes.

Q. I know you didn't review any of the postoperative radiographic imaging. Did you review any of the preoperative radiographic imaging in this case?

A. I don't believe I received actual images, I did receive reports.

Q. Reports. Okay.

MR. THOMAS: I appreciate your time. That's all of the questions I have for right now. And with the understanding that if anything changes, we can finish up.

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EXAMINATION

BY MR. MEYERS:

Q. Just a quick question.

Positioning of the patient in the case may affect blood flow to the brain depending upon --

A. Yes.

Q. -- the patient positioning, which can be highly variable?

A. (Nonverbal response.)

Q. Yes?

A. Yes.

MR. MEYERS: That's it.

FURTHER EXAMINATION

BY MR. THOMAS:

Q. One last question then.

When doing a minimally invasive or a robotic-assisted mitral valve replacement, the patient is placed in a supine position?

A. Supine position. Some surgeons, based on body habitus, may elevate the right hip or the right side 30 degrees. But depends on the body habitus of the patient.

MR. THOMAS: Great. Thank you. Appreciate it.

(FURTHER DEPONENT SAITH NAUGHT.)

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STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)

I, Kyla Elliott, a Certified Shorthand Reporter in the State of Illinois, do hereby certify that heretofore, to-wit, on the 22nd day of January, 2016, personally appeared before me, at 4646 Marine Drive, Suite 7C, Chicago, Illinois, EDGAR CHEDRAWY, M.D., in a cause now pending and undetermined in the Circuit Court of Macomb County, Michigan, wherein DRAGO KOSTADINOVSKI AND BLAGA KOSTADINOVSKI, AS HUSBAND AND WIFE are the Plaintiffs, and STEVEN D. HARRINGTON, M.D., AND ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C. are the Defendants.

I further certify that the said EDGAR CHEDRAWY, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.

I further certify that the taking of this deposition was pursuant to notice and that there were present at the deposition the attorneys hereinbefore mentioned.

I further certify that I am not counsel for nor in any way related to the parties to this suit, nor am I in any way interested in the outcome thereof.

IN TESTIMONY WHEREOF: I have hereunto set my verified digital signature on this 3rd day of February, 2016.

_____

NOTARY PUBLIC, COOK COUNTY, ILLINOIS
LIC. NO. 084-004264

EXHIBIT 6

KOSTADINOVSKI, ET AL. v. HARRINGTON, M.D., ET AL.

LOUIS SAMUELS, M.D.

January 25, 2016

Prepared for you by

BIENENSTOCK
NATIONWIDE COURT REPORTING & VIDEO

Bingham Farms/Southfield • Grand Rapids
Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI AND)
BLAGA KOSTADINOVSKI, AS)
HUSBAND AND WIFE,)
Plaintiffs,)
)
- vs -) NO. 14-2247-NH
)
STEVEN D. HARRINGTON,)
M.D. AND ADVANCED)
CARDIOTHORACIC)
SURGEONS, P.L.L.C.,)
Defendants.)

ORAL DEPOSITION OF
LOUIS SAMUELS, M.D.
JANUARY 25, 2016

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EXHIBITS

Oral deposition of LOUIS SAMUELS, M.D. Witness, on behalf of the Defendants, pursuant to the Michigan Rules of Civil Procedure, taken at Bryn Mawr Hospital, Galen Rogers Conference Room, 1st Floor, East Wing, 130 South Bryn Mawr Avenue, Bryn Mawr, Pennsylvania, January 25, 2016, commencing at or about eleven o'clock a.m., Eastern Standard Time, before Maureen Walker, Professional Court Reporter - Notary Public.

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(Curriculum Vitae received and marked for identification as Exhibit 1.)

MR. THOMAS: Let the record reflect that this is the deposition of Louis Samuels, M.D., taken pursuant to notice and upon agreement of counsel. It may be used for impeachment purposes only at the time of trial.

BY MR. THOMAS:

Q. Dr. Samuels, I introduced myself to you before we got started today. My name is Matt Thomas. I represent a cardiothoracic surgeon by the name of Dr. Harrington.

It's my understanding that you have agreed to act as an expert for the plaintiff in this case. Is that true?

A. That is correct.

Q. How many times have you had your deposition taken, sir?

A. Probably a dozen times over the last 20 years.

Q. Okay.

And in those 12 deps, were you acting as an expert witness, as you are doing

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today, or was it as a party or a witness to another type of action?

A. As an expert witness.

Q. Okay. We'll talk about that in a little bit.

I'm going to show you what I've previously marked as Exhibit Number 1, and it's a copy of your CV dated January 25, 2016. I assume that is reasonably up to date and current. Is that fair?

A. Yes, it is.

Q. Okay.

And I'm not going to spend a long time going through it. But just generally speaking, you are Board certified by the American Board of Thoracic Surgery?

A. Yes.

Q. Board certified by the American Board of Surgery?

A. I was. I did not renew it.

Q. Okay.

And that was just a choice of yours not to renew as opposed to your credentials or your certification wasn't curtailed in any way?

A. That's correct. It was my choice not to renew.

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Q. Tell me a little bit. What is your profession?

A. Adult cardiothoracic surgery, which involves heart and lung surgery. Although I don't do as much lung surgery now as I did after my training. But it's confined to adults 18 and up, and it involves all aspects of cardiac surgery, including transplantation, artificial heart technologies, as well as the more common coronary bypass operations, valve surgeries and aortic surgery.

Q. All right. Thank you.

Can you give me an approximate breakdown of your heart versus lung or your --

A. At present, it's probably 99 percent heart, one percent lung. And that happened -- that transition to that happened probably about five years ago where I was doing probably a quarter, 25 percent lungs, 75 percent heart.

We hired several noncardiac thoracic surgeons to do the lung surgery, so I have given that over to those colleagues.

Q. You are -- strike that. If we just take your heart practice for a minute, your

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cardiovascular practice, how much of that is comprised of valve surgery?

A. I would say probably 20 percent at most is probably valve surgery, and 70 percent would be coronary bypass surgery, and the other ten percent would be all the other miscellaneous things like transplants, artificial hearts, aortic aneurysms, dissections, cardiac tumors, the more miscellaneous ones.

Q. When you talk about the 20 percent of that being valve surgery, does that include both stand-alone valve repair or replacement versus those that are done in conjunction with your bypass, for instance?

A. That would be both.

Q. Okay. Thank you.

Do you utilize robotic assisted?

A. I do not.

Q. Have you ever?

A. Yes. Strike that. I have not used robotic assisted. I have in the past used a port access minimally invasive approach but not robotic.

Q. Have you trained on the Da Vinci Robot for any type of procedure?

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A. I have not trained on the Da Vinci Robot.
Q. I did see that you did some postgraduate training in pediatric cardiothoracic surgery, but pediatrics does not make up any percentage of your practice, fair?
A. That's correct.
Q. Okay.
Also on your CV, I understand that you have a number of hospital appointments. Where do you spend the majority of your time?
A. Yes. The majority is spent in the Main Line Health System hospitals, Lankenau Medical Center, Bryn Mawr Hospital, Paoli Hospital and Thomas Jefferson University Hospital. Those are the four I spend time at, and the majority of my time would be Lankenau Medical Center, Paoli Hospital and Thomas Jefferson University Hospital.
Bryn Mawr Hospital at present does not do heart surgery. We did in the past. But at present, we send that material to Lankenau Medical Center.
Q. I got you. And by whom are you employed?
A. Main Line Health System.
Q. Is it a medical group where you have

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partners, or is it, for lack of a better term, everyone for themselves?
A. No. It is a group. The physician entity, group entity, is Main Line Health Care, and they are the physician entity of the Main Line Health System.
Q. Fair to say you have never had any issues with your licensing or credentials?
A. Correct, I have had no issues.
Q. I have noted that you have numerous presentations and publications. Any of those presentations or publications that you believe are germane to the issues in this case?
A. No, I do not.
Q. Are you relying on any particular literature in support of your opinions today?
A. Not specifically. However, in preparing for the case, I have read -- when I initially received the case, I have read through search engines, such as Pub Med.
Q. Sure.
A. I have read articles related to it, but I don't have them specifically with me or at my disposal. Just to, for lack of a better word, corroborate or validate my training and

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practice and the issues related to this case.
Q. And if for some reason down the road we were to need you to actually go back and pull that literature that you believe corroborates your opinions in this case, that would be something you would be able to go and do?
A. I believe I could, yes.
Q. Now, you and your attorney, or counsel for Mr. Kostadinovski, I should say, were kind enough to let me go through your materials before we got started. I just want to make sure the materials that we have in this giant box here, is that everything you have reviewed in this case?
A. It is.
Q. Just so that the record is clear, you have reviewed the deposition of Lynn Masinick, the perfusionist?
A. Correct.
Q. You have reviewed volumes 1 and 2 of Dr. Harrington's deposition?
A. I did.
Q. There is a purple folder that is titled Kostadinovski case, and there is some materials, including my deposition notice and

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appears to be some select records from Henry Ford Macomb Hospital. Did you review these?
A. Yes.
Q. Did you pull these particular records from the binders that are contained in this box, or was that something that was sent to you like this?
A. It may have been a little bit of both. I probably pulled them from the binders. There may have been other records that were sent to me electronically that I printed. So, it's probably a little bit of both.
Q. You also have the complaint and demand for jury trial which was filed in this case, correct?
A. Yes.
Q. Is that something you reviewed?
A. Yes.
Q. Did you review the affidavit of Dr. Chedrawy?
A. I'm sure I did at some point.
Q. That's plaintiff's other cardiothoracic surgery expert?
A. I'm sure I did.
Q. Do you know if you reviewed Dr.

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Harrington's outpatient office chart?
A. If it was part of those records, I would have. I just don't have an independent recollection of doing that. But if it's part of that material, then I would have.
Q. And I'll take a look in a minute. There is a number of CDs that are rubber-banded together, and it appears that these are radiologic imaging from several Henry Ford facilities, including Henry Ford Macomb, Henry Ford West Bloomfield, Henry Ford Lakeside, some more from Henry Ford Macomb, some more from West Bloomfield and again Henry Ford Macomb.
Did you review all the films that are contained on these disks?
A. No, I did not.
Q. Okay.
Did you review any of the films that were contained?
A. I reviewed the chest X-rays, particularly those preoperatively and around the time of surgery. I reviewed one or two of the head CT scans. And that was about it.
Q. Okay.
Now, also the binders that I

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previously mentioned, we have -- and I have looked at these already. They're labeled Henry Ford Macomb Binder 1 through five, and there are five binders here.
Again, I suspect that you have looked at the records that you believe are pertinent to your review in this case as opposed to studying each and every page of these records. Is that fair?
A. That's absolutely fair.
Q. And let's see if we can get to the bottom of whether or not you looked at Dr. Harrington's outpatient chart. I see some tabs for outpatient, but I don't see any actual records behind that.
As you sit here today, you don't have a recollection of reviewing any of his office notes; is that fair?
A. Yes, that's fair.
Q. Tell me a little bit about your expert review experience. I know you indicated that you have been deposed in the past. Approximately how many times -- strike that. When did you begin reviewing as an expert?
A. Probably about 15 years ago. And it was very, very rare, and I can't even recall the

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circumstances of how it came about to pass. But probably about 15 years ago, and I guess I'll just give you the evolution of that.
Q. Sure.
A. It was in the beginning, probably for the first several years, mostly, if not exclusively, defense work. That was just what came across my practice and my table. And again, I don't advertise this, and I don't have any relations in any sort of contractual way with anyone to solicit material.
There is a nonagreement connection with a person, Guy Sapanaro, but I have never signed anything, and I certainly don't advertise, nor does he advertise me, but on occasion, I will get a phone call from him or an e-mail from him asking if I would be interested in reviewing a case.
And I would look at the merits of the case and determine if I was in a position to be an expert in the case. So, that is my only connection. But as I evolved from doing mostly defense work in the beginning, I started to see some more plaintiff work and more frequency of it, so that I would say it evolved from mostly

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defense work to maybe half and half, defense/plaintiff and then probably two-thirds/one-third plaintiff/defense at the present time.
So, I still do both. I still look at the merits of each case and make a determination as to whether I'm in a position to opine on anything related to the case.
Q. Let me ask you a little bit about that. For how long has it been two-thirds plaintiff versus one-third defense?
A. Probably the last several years, within five years, I would say.
Q. And approximately how many new cases are you reviewing per year, per month, whatever is easiest for you?
A. Recently it's probably been anywhere from six to ten a year for the last one or two years but less than that before that. So, it's picked up in the last one or two years.
Q. Have you reviewed cases out of the State of Michigan in the past?
A. In the State of Michigan?
Q. Yes.
A. I think I have. Again, I can't recall exactly, but I think I have.

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Q. Have you reviewed for Mr. Takala or Mr. Meyers in the past?
A. I'm trying to remember that. Do you recall? I can't keep track.
Q. He is not under oath.
A. I'm sorry.
Q. That's fine.
A. I just don't remember. I may have.
Q. That's fair.
A. I can't keep track.
Q. Do you know if you have ever come to Michigan to testify at trial?
A. I may have.
Q. What makes you think that you may have?
A. It just sounds like I did. I do so much traveling. I can't keep straight whether I was there for a meeting or a case or whatever. But somehow I feel like I have been in Michigan maybe once in the past for a case.
Q. How many times have you been to trial where you have given testimony?
A. Probably a half dozen times over the last 15 years.
Q. Okay.

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And I think you already told me you have given about 12 deps over the years?
A. Yeah, 12 to 20. Maybe if I think about it a little more, probably 12 to 20 over the last 20 years.
Q. When was your last deposition before today?
A. I don't want to mislead you. Let me think.
Q. Approximately?
A. Within the last six months.
Q. Have you ever reviewed a case at the request of an attorney representing a surgeon in the State of Michigan, if you know?
A. I don't recall.
Q. Where do you get your defense cases? From what states?
A. Mostly Pennsylvania. I think I have had one in the Allentown area and in the Philadelphia County.
Q. Do you know any names of any of the defense attorneys that have retained you?
A. I don't.
Q. Do you know any of the attorneys' names of plaintiffs that have retained you?

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A. I don't remember.
Q. Have you reviewed cases involving mitral valve repairs in the past?
A. No.
Q. This is your first mitral valve case?
A. Yes. Can I amend that?
Q. Sure.
A. It just dawned on me because I'm actually looking at a case now that I believe was a mitral valve case in which a catheter was accidently sewn into the suture line of the operation and had to undergo a secondary operation to remove the catheter and complications related to that.
So, it's not the actual valve per se, but it was a valve operation. I believe it was a mitral valve case. For the life of me, I can't remember what state it is or where things lie.
Q. Do you know who retained you in that case?
A. I do not.
Q. Did you offer an opinion that the surgeon was negligent or not negligent?
A. Yes. I offered an opinion that there

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was negligence.
Q. What is your fees for -- speaking of, I owe you a check. I just remembered. What are your fees for review?
A. It's $500 per hour for record review.
Q. Do you know how many hours you have spent in reviewing this case?
A. I didn't total them up, but if you would like, I can estimate here and now.
Q. Sure. An estimate would be great.
A. You see the binders and CDs and everything, it's probably between 15 and 20 hours of work.
Q. And what do you charge for deposition?
A. Well, my fee schedule says $5,000 for the day.
Q. Right.
A. But I think we've made some understanding that --
Q. I believe that's correct and I'm going to --
A. We amended that to a lower number to accommodate each of us.
Q. That's great. And I promise it's not going to take all day. In fact, if we take two

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hours, I would be surprised.
A. Thank you.
Q. There is a check for the amount that we'd agreed upon. And I wouldn't know what to ask you for a full day.
A. Thank you.
Q. What are your fees for a trial?
A. It's also $5,000 for the day.
Q. If this case were to go to trial, would you be okay with traveling to the State of Michigan and coming in live?
A. Yes.
Q. Have you authored any type of written report, whether it was electronic or typewritten or handwritten, in this case?
A. No.
Q. Do you know Dr. Harrington?
A. I do not.
Q. Do you know Dr. Chedrawy, the other plaintiffs' expert in this case?
A. I do not.
Q. Do you know Dr. J. Michael Smith from Cincinnati who is the defense expert in this case?
A. I do not.

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Q. Have you been named, Doctor, as a defendant in a medical malpractice lawsuit?
A. Yes, I have.
Q. Okay.
On how many occasions, if you remember?
A. I would say, again, in about 20 years, probably a half dozen cases.
Q. Any of those involve a mitral valve repair?
A. No, they do not.
Q. Do any of the hospitals that you are on staff at have the Da Vinci Robot available?
A. Yes. Two of the four, Paoli Hospital and Lankenau Medical Center. Now, from the standpoint of having the robot and using it for heart surgery, it's almost exclusively Lankenau Hospital that uses the robot for heart surgery.
But the robot is available at Paoli Hospital, and it's used almost exclusively for noncardiac surgery, urology and lung surgery, but noncardiac.
Q. Got you. Do you have any partners that are sort of the go-to guy or girl for the Da Vinci Robot for heart procedures?

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A. Yes. Dr. Sutter, Francis B. Sutter.
Q. How do you spell that?
A. S-U-T-T-E-R.
Q. Thank you.
A. He is our go-to guy for robotic hearts.
Q. When you do mitral valve procedures, are you doing sternotomies or are you doing -- because I think you mentioned you do some minimally invasive, but are you still doing minimally invasive?
A. No, I'm not. I'm not doing that. Our go-to guy for mitral valve surgery is Dr. Goldman, G-O-L-D-M-A-N.
Q. What is his --
A. Scott, S-C-O-T-T. And I have worked with him on cases, but he is our primary mitral valve surgeon, and he does almost exclusively the minimally invasive port access approach, and I have worked with him in the past.
And occasionally, rarely at present, but occasionally, I do participate in the structural heart program, which includes that, at a sort of confidence meeting level and discuss cases and things of that nature.

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I used to do the minimally invasive before being recruited to the Main Line Health Center in 2003. So, that was something that was part of my practice prior to that, but because of the nature of our practice, we have earmarked the different surgeons to do different things.
Q. Where were you before Main Line?
A. I was at Hahnemann University Hospital in Philadelphia.
Q. Do you know when you were first contacted in this case approximately?
A. I think it may have been December of 2014. I think that might be right.
Q. If you know, how was it that Mr. Takala or Mr. Meyers knew of your availability to review cases?
A. You know it's a good question. I don't remember how they got to me. I don't think it was through Mr. Sapanaro, but it may have been. I simply don't remember.
Q. And you don't have a specific recollection whether or not you have worked with them in the past?
A. That's right, I don't have a specific recollection. It could be that I did work with

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them before and they have asked me to work with them again. That's very possible.
Q. I assume the reason I'm sitting in this conference room is that you have opinions in this case where you believe that my client, Dr. Harrington, violated standard of care, correct?
A. Correct.
Q. And you are familiar with the standard of care?
A. I am.
Q. And why don't we just generally talk a little bit about your opinions, and if you could just in whatever way that makes the most amount of sense tell me, and we'll go back and I'll find some specifics to ask you.
Okay?
A. Fair.
Q. Just so the record is clear on what my question is, please tell me what criticisms you have that you believe rise to the level of a breach of the standard of care. Sometimes people have criticisms, but they're not breaches.
And while I'm happy to talk

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about those maybe at another time, I am really interested in what you believe was a violation of the standard of care in this case.
A. Yes, sure. Stop me if I'm rambling, but I'll try to be concise and efficient.
Q. Sure.
A. So, in reviewing the case, as a background, I don't have any criticism of the need for the surgery and its indications. Where I specifically found breaches in the standard of care have to do with the conduct of the surgery intraoperatively and the necessary work-up preoperatively.
And more specifically with regard to those two areas starting with the preoperative work-up, I was noticing the absence of a complete assessment of the aorta and its branches in order to safely conduct the kind of minimally invasive approach that a robotic mitral valve repair warrants. I can articulate that a little more in a second.
Q. Sure.
A. The second area relates to the intraoperative conduct of the surgery and specifically related to the anemia that was

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evident through the time the patient was on the heart-lung machine. And I'll, again, get more detailed with you in a second.
So, those are the two areas, preoperatively and intraoperatively. Preoperatively the accurate assessment of the aorta and its branches, and intraoperatively the anemia during the heart-lung machine parts of the procedure.
Q. All right.
Let's start with the preoperative assessment.
A. Yes.
Q. What specifically do you believe the standard of care required Dr. Harrington to do or not do preoperatively in this case?
A. Yes. So, in general terms, the answer is a thorough accurate assessment of the aorta and its branches, meaning not only the thoracic aorta, the abdominal aorta, and the iliofemorals. What is required is whatever imaging modalities will give you that accurate answer.
And that would include, in my opinion, angiography, specifically CT, computer

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tomographic angiography preoperatively, particularly if you are going to conduct this in a minimally invasive approach using the femoral artery.
Q. Let me ask you this question: In 2011, you were not doing minimally invasive mitral valve repair; is that fair?
A. Personally, no, I was not. But I was involved with the team, and I have assisted in those cases and have discussed the issues related to it in our structural heart group. So, I'm familiar with it.
But to answer your question specifically: I was not doing them as the primary surgeon.
Q. And if I understand your previous testimony, you haven't been doing minimally invasive mitral valve repair since 2003 or before 2003 before you came to Main Line Health System, correct?
A. That would be correct.
Q. Okay.
Do you utilize an endo clamp for purposes of -- what is the word I'm looking for -- stopping the blood to the heart?

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A. I do not.
Q. Okay.
You utilize an external aortic cross clamp?
A. Correct.
Q. Have you ever utilized an endo clamp in your practice?
A. Again, before 2003, yes.
Q. You don't have any criticisms with the selection of using an endo clamp. Your criticisms lie in the preoperative work-up to assess the abdomen because of the risks that that endo clamp going up through the femoral artery pose; is that fair?
A. Let me clarify that a little bit.
Q. Sure. Maybe I misunderstood.
A. No. I think I know what you are asking, but I just want to be clear. So, the criticism is to the extent that the imaging necessary, in my opinion, was not complete without the CT angiography. And that does relate to the use of the endo clamp and also the approach to the profusion of the body through the femoral artery in a retrograde fashion.
And, so the port access or

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robotic approach utilizes equipment in which the femoral artery is cannulated and flow is directed upward in the aorta. And without clarity of the state of the aorta, whether it's diseased or not diseased, there can be the potential for complications related to things like stroke due to the presence of disease within that aorta.
So, it may involve the actual endo clamp or endo balloon, as it's referred to, or it could simply be on the basis of the retrograde blood flow itself irrespective and separate from the balloon. And again, without the clarity of the imaging preoperatively, you are predisposing the patient at risk for a complication related to either retrograde flow and/or the balloon.
Q. In this case, is it your opinion that the patient suffered a stroke as a result of either the endo clamp or the retrograde flow?
A. It's quite possible.
Q. Can you say more probably than not?
A. I would say more probably than not, yes.
Q. Okay.
So, in this case, you believe

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that the stroke in this case was an embolic event versus some sort of malperfusion or low flow state; is that fair?
A. I would say that in reviewing the records, it's perhaps a combination of embolic and the anemia associated with the operation during the period of time on the heart-lung machine. Because there has to be a distinction between pressure and flow and red blood cell count.
Q. Okay.
A. So, I can explore that with you a little more, but the flow or the malperfusion, I think was the term you used, I'm not sure exactly how you're defining that. But what I'm suggesting is that the flow was adequate, the pressure for the most part was adequate.
However, the oxygen carrying capacity was inadequate due to the profound anemia during the course of the operation on the heart-lung machine. So, could you define malperfusion on the basis of normal flow, normal pressure and anemia? Yes, if that's how we want to define it.
Q. And I appreciate that. So, let me back up so that we are clear. You believe that

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the stroke -- you told me that you believe more probably than not this was related to -- this being the stroke, was related to the utilization of an endo clamp or because of the retrograde flow, correct?
A. Yes.
Q. You also believe that the anemia or the oxygen capacity of the blood because of the anemia also was a cause of the stroke; is that fair?
A. Yes. I believe it was a contributing factor, yes, I do.
Q. What are you basing that on?
A. I'm basing that on the records I read from the neurology consults, from the radiology of the head reports. And they indicated on their reports and on their consultations that there were both embolic strokes, particularly on the right side, and also the term that was used in some of the radiology reports was watershed infarct.
So, I saw both interpretations of the brain CT scans and of the consultations, and those were the opinions of these radiologists and neurologists, and I think even a neurosurgeon

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was consulted. So, that is the basis of my opinion.

MR. THOMAS: And I guess, Tim, this is more of a question for you. Understanding that Dr. Samuels is a cardiothoracic surgeon, is it going to be your intention to utilize him to offer what kind of strokes these were or what caused the strokes?

I know I asked the question, and I appreciate the answer. But given that you do have a neuroradiologist as well as a neurologist in this case, I don't want to waste time asking questions about this if you are not going to present him for that.

MR. TAKALA: No. I think you're spot on, Matt. I think that Dr. Samuels can talk about his understanding of what the radiologist said and the relationship between what he believes was a standard of care and what the radiologist reported on. But we do not intend to offer Dr. Samuels

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to explain what type of stroke it was and where it came from.

MR. THOMAS: Thank you.

MR. TAKALA: Otherwise proximal causation testimony.

MR. THOMAS: Thank you.

BY MR. THOMAS:

Q. I think I understand your opinion, Doctor. I want to go back to this preoperative assessment. Just so I understand, you believe the standard of care requires CT angiography in order to thoroughly and accurately assess the aorta and its branches; fair?

A. I believe that is a fair statement, yes.

Q. Is there anything else that a surgeon can utilize, any other tools a surgeon can utilize, to examine and perform a thorough and accurate assessment of the aorta and its branches prior to performing a robotic assisted mitral valve repair?

A. There are other imaging modalities. MRI, MRA, magnetic resonance imaging, magnetic resonance angiography, comes to mind. There is also echocardiography and traditional standard

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angiography.

Now, I would like the opportunity to just comment on some of the things related to echocardiography and the standard angiography.

Q. Before you do, and I don't want to cut you off, but I want to make sure that first I get a response. I want to make sure my questions are answered.

A. Yes, of course.

Q. And then I'll let you expound as you feel necessary.

First of all in this case, Dr. Harrington, you read his testimony?

A. Yes.

Q. He did testify that he reviewed certain studies in an effort to make a determination one way or another whether the aorta was diseased or calcified, correct?

A. Correct.

Q. And he looked at the chest X-ray, correct?

A. Correct.

Q. You looked at the preoperative chest X-ray as part of your evaluation in this case retrospectively, correct?

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A. Correct.

Q. Okay.

And why did you look at the chest X-ray?

A. I wanted to see if there was anything on the chest X-ray that might suggest there might be disease of the aorta.

Q. And you didn't see anything on that chest X-ray that suggested disease of the aorta; is that fair?

A. That's not fair.

Q. Okay.

What did you see on the X-ray?

A. Actually I did see on the aortic knob, which is part of the arch of the aorta, a rim of calcium, and that was the only aortic abnormality that I noticed.

But I saw that on several films to make sure that it wasn't some artifact. I saw it preoperatively on the films and perioperatively on the post-op films. So, I did see an abnormality there.

Q. It is not your testimony today that that calcification or that calcium you saw in the rim of the aortic knob was the cause of the

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stroke in this case, correct?
A. It is not my testimony, no.
Q. Now, there's other things that Dr. Harrington also looked at preoperatively in his assessment of the aorta; is that correct?
A. Yes.
Q. He looked at the echocardiogram that we talked about or that you had mentioned, correct?
A. Correct.
Q. And is that an appropriate -- strike that. That is an appropriate examination -- let me start again. That is an appropriate diagnostic tool for a surgeon to utilize to help assess the aorta, correct?
A. It is one of them.
Q. Okay.
And did you find anything -- did you have the echocardiogram's films?
A. No.
Q. Or views?
A. No.
Q. What do they call them?
A. The imaging.
Q. Imaging. Thank you.

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A. I did not.
Q. So, whether or not the preoperative echo in this case showed anything that would suggest a diseased aorta, you don't have an opinion one way or another because you have not seen that, correct?
A. That's correct.
Q. Okay.
In addition, was there anything else Dr. Harrington looked at prior to the robotic assisted mitral valve repair in this case; do you remember?
A. Well, he would have looked at the cardiac cath, and I don't have that image to look at myself either. And I am a little confused to a degree that the testimony I think I read in Dr. Harrington's deposition was that the cardiac cath showed areas of the aorta as part of the cath.
I couldn't get more specific than that because I don't remember exactly the verbiage he used for that. But I thought I recalled him in his deposition commenting on that. However, when I reviewed the report of the cardiac cath, it only mentions the coronary arteries.

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It doesn't mention anything about the aorta and about any other part of the aorta going down to the abdominal aorta and iliofemoral. So, I don't know without seeing the actual cath itself whether or not there was any imaging on that to determine whether there was anything abnormal because it's not in the report.
Q. Okay.
Just so I'm clear, you are not testifying today that Dr. Harrington was making that up; you are just suggesting that you have not seen the imaging from the cardiac cath and because the report is silent, you are not sure what it shows?
A. Correct.
Q. Let me ask you a question: Where is it that you -- strike that. You indicate that standard of care requires CT angiography for purposes of --
(Discussion off the record.)
BY MR. THOMAS:
Q. Let me start again.
A. Yes.
Q. You indicated that you believe the

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standard of care requires CT angiography prior to a procedure such as the robotic assisted mitral valve repair that Dr. Harrington performed in December 2011, correct?
A. Correct.
Q. Where is it that you or how is it that you are familiar with the standard of care -- let me back up. Let me see if I can word or put together or formulate some sort of proper sentence, which apparently is tough for me today.
I'm going to jump back once. The CT angiography, you mentioned earlier that you had done some general literature searches that you were performing related to the CT angiography?
A. Yes.
Q. Was the general literature searches -- and we're going to go to it in a minute-- involved in the anemia issue as well?
A. Separate literature search.
Q. As we sit here today, can you cite to any specific literature that suggests that CT angiography in 2011 was the standard of care prior to a surgeon undertaking a robotic assisted mitral valve repair?

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A. I can't cite specifically. I can only recall in general terms that there was literature both before and after 2011 that recognized the value and importance but not specifically whether or not it was standard of care at the time of this particular case, no.
Q. And I guess that is my question because we all understand that medicine is a dynamic art, correct?
A. Correct.
Q. It is changing every day, correct?
A. Yes.
Q. And what is standard of care today may not have been standard of care in 2011, correct?
A. Correct.
Q. So, my question for you, Doctor, is with that understanding, is it still your testimony that in 2011, the standard of care did require CT angiography prior to a robotic assisted mitral valve repair?
A. It will not be that. I have to confess and admit to you that from what I read and in my training, including the minimally invasive, that it is -- CT angiography was in existence at that time and was strongly

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recommended in practice for this approach. However, I can't point to a particular reference that might make the point that it was at that time a standard of care. I guess that answers your question directly.
Q. It does. And I just want to follow up.
MR. THOMAS: Tim, if you want to jump in just so that we are on the same page and I can move on.
BY MR. THOMAS:
Q. So, I know you indicated to me earlier that you believe that there should have been CT angiography, and oftentimes what we see when I question surgeons or other experts is they say well, I also do CT angiography before I do minimally invasive and all my partners do.
But with the understanding that that is not the standard of care in Michigan, by the law the standard of care is what the average, reasonable and prudent similarly qualified specialist would have done under the same or similar circumstances.
If I can just summarize what you just told me so that we can move on. While you believe that CT angiography was a good practice

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and it was in existence in 2011, you cannot testify -- as we sit here today, you cannot testify that it was the standard of care in 2011 for a cardiothoracic surgeon to perform a preoperative CT angiograph before this type of procedure?
A. I can't point to any reference or a guideline that would state that.
Q. Okay.
MR. THOMAS: I'm going to ask Tim to jump in just to help me out here.
MR. TAKALA: Let's go off for just one second.
(Discussion off the record.)
BY MR. THOMAS:
Q. I think one more question before we leave this topic, Doctor.
It will not be your testimony at the time of trial in this case that Dr. Harrington violated the standard of care by failing to do a preoperative CT angiogram before the December 2011 robotic assisted mitral valve repair, correct?
A. Well, so, I'm going to hedge a little bit only because part of my criticism is that

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the imaging of the aorta was, in my opinion, incomplete. And CT angiography was in existence at that time and was strongly recommended by many of the things that I have read even at that time.
To say it wasn't a standard of care, I will concede to that. However, it doesn't dismiss the necessity to evaluate that aorta with studies and imaging tools that were available at that time to assure a safe operation to avoid neurologic complications. So, I guess I'm qualifying my answer but also answering your question.
Q. Instead of moving on then, I'm going to have to explore that a little bit more. So, I understand your point with respect to you have seen some written literature that suggests that it's a good tool to use. You understand that surgeons oftentimes do things in different ways, correct?
A. Yes.
Q. You understand that there might be a surgeon who would do CT angiography before this type of mitral valve repair, but there is also other surgeons who are going to testify in this

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case that they don't do CT angiography before a robotic assisted mitral valve repair.
Okay?
A. Yes.
Q. You understand that?
A. Yes.
Q. And you accept that as being a part of this world, this cardiothoracic surgery world, that surgeons oftentimes have different practices, correct?
A. Correct.
Q. And the fact that both surgeons might be reasonable and prudent and both very well qualified, correct?
A. Yes.
Q. Okay.
In this case, Doctor, what -- let's put CT angiography out of it for a minute. Other than CT angiography, do you have an opinion that Dr. Harrington violated the standard of care in his preoperative assessment of the aorta?
A. No.
Q. So, the only test that you suggest that -- and I'm going to use specific terms, so

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listen to me. The only thing that you suggest that he should have done, and I'm saying you, not the standard of care, is that you think because CT angiography was around and based on what you reviewed, you think it would have been a good tool to utilize in this case, correct?
A. Yes.
Q. But you are not sitting here telling me that he violated the standard of care with respect to his preoperative assessment of the aorta, correct?
A. That is fair.
MR. THOMAS: I think that clarifies it.
MR. TAKALA: I think so too.
MR. THOMAS: Obviously if it doesn't and we have to, we'll come back at a later day.
BY MR. THOMAS:
Q. I want to move onto your other criticism with respect to the intraoperative management of Mr. Kostadinovski. And after I make a quick statement on the record and certainly Mr. Takala can respond to it if he needs to.

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MR. THOMAS: To the extent that the assertion in this case is that given the decrease in hemoglobin and hematocrit at 11:24 during the surgery while the patient was on bypass and it's alleged that the standard of care required Dr. Harrington to transfuse the patient, I'm going to object to that testimony and move to strike it because it wasn't pled in any Affidavit of Meritorious Claim in this case, nor was it pled in a Notice of Intent.
I believe all those records were available and with plaintiff's counsel. That being said, I will also make for the record that I was alerted by both Mr. Meyers and Mr. Takala in advance, so I wasn't surprised today at today's deposition that those were going to be the opinions.
But I was notified by Mr. Meyers last week shortly before Dr. Chedrawy's deposition and by Mr. Takala, and I spoke before the

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deposition with Dr. Samuels today. So, with that being said --
MR. TAKALA: I would just say I am sure that Jeff probably made a record at Dr. Chedrawy's deposition, and certainly we wouldn't waive any rights to amend theories. We just took the deposition of the perfusionist, and the deposition will speak for itself.
So, I don't want to waive any argument that we might have later. Certainly we'll let Matt question Dr. Samuels on those theories, and we can sort out whatever legal issues we need to with the judge.
MR. THOMAS: I agree. And I certainly wouldn't suggest you waived anything.
MR. TAKALA: Thank you.
BY MR. THOMAS:
Q. All right.
So, I want to talk about this anemia issue for a minute, Doctor, and I

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would assume that -- I'm going to be referring to Exhibit 2 to Ms. Masinick's deposition, and I'm going to hand you your copy because I assume that is the bypass record that you are referring to and that you are relying on, correct?

A. Correct.

Q. Okay.

And in looking at that, I assume that you believe that the first time at which the patient was -- strike that. You believe that the first moment where there was a decrease, concerning decrease, in hemoglobin or hematocrit was at 11:24 when the hemoglobin was documented at 5.1 and the hematocrit was 15, correct?

A. Correct.

Q. And then you recall from the testimony of Ms. Masinick that following the 11:24 returns of the hemoglobin and hematocrit, she did another re-draw?

A. Yes.

Q. And that was reported at 11:32 on this document, again, Exhibit 2 to Ms. Masinick's dep?

A. Yes.

Q. And then 11:32, the hemoglobin again

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was noted to be 5.1 and hematocrit at 15, correct?

A. Yes.

Q. It remained at that level until it was reported at 12:00 p.m. when the hemoglobin rose to 7.1 and the hematocrit to, I thought it was 23, maybe it's 21?

A. Yeah. There is one more 5.1 in between though at 11:51.

Q. I thought I mentioned that. If I didn't --

A. So, there is three of them. There's 5.1 at 11:24, 5.1 at 11:32 and 5.1 at 11:51. And then it looks like it's 12 o'clock, although it's a little hard to read, but it looks like it's at 12 o'clock that the hemoglobin is up to 7.1.

Q. What do you attribute the rise in hemoglobin and hematocrit, at assuming that's 12 o'clock, too?

A. I believe if I read both the deposition of the perfusionist and looking at the record here, they were hemoconcentrating the blood, trying to concentrate it more. Because I don't see a record of a transfusion here at that time.

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Q. And I think you are correct that Ms. Masinick indicated that at 11:30, she hooked up a vacuum up to her hemoconcentrator in order to more aggressively hemoconcentrate the patient, correct?

A. Yes. And I see that documented here also on this chart.

Q. Right. And the chart, again, we're referring to Exhibit 2 to Ms. Masinick's deposition. You don't have any problems with the aggressive hemoconcentrating the patient based on those hemoglobin and hematocrit values, correct?

A. I don't.

Q. What is it that you believe the standard of care required of Dr. Harrington with respect to the first report of a decrease in hemoglobin and hematocrit at 11:24?

A. Transfusion.

Q. Okay.

Are there other types of corrective measures that can be done other than transfusion and hemoconcentrating the patient?

A. No, I don't think so.

Q. Okay.

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Even in the face of having the hemoglobin and hematocrit being corrected via just aggressive hemoconcentrating, is it still your opinion that a transfusion was also required?

A. Yes. Because the repeat hemoglobins were still far below, in my opinion, the standard of care, which in my opinion is a hemoglobin of 7 or higher, and we only achieved that at 12 o'clock. If you'll notice after 12 o'clock, it dropped again below 7 to 6.8, 6.5, 6.5, 6.5 and then again finally later on up to 7.1. So, it remained well below a hemoglobin of 7 for a good portion of the operation.

Q. What do you believe caused the anemia in this case?

A. Well, there is a number of things that could have caused it. Part of it is going to be hemodilution just from the heart-lung machine. We call it prime, it's non-blood fluid that will dilute the red cell concentration, so that's part of hemodilution.

And then maybe there is also some blood loss associated with the heart surgery. So, those would be the two major areas that would

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cause a drop like that.
Q. Did you see any evidence in the records that you reviewed of any occult blood loss?
A. I did not.
Q. Okay.
Is it your opinion that more likely than not this was related to hemodilution as a result of priming the heart-lung machine?
A. More likely than not, that's correct.
Q. Did you have a chance to review either through via the perfusionist's record or the anesthesia record in this case with respect to the amount of non-blood fluid that was given to Mr. Kostadinovski?
A. I did review it. I just can't recall the exact numbers. But I did look at those numbers. I remember looking at them.
Q. In looking at those numbers, did any of those stand out to you as being outside the realm of what you would expect to see for an operation like this?
A. Not really.
Q. Okay.
Do you know how long it takes

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after this non-blood fluid is given to the patient before the hemoconcentrator to actually start working?
A. I don't know.
Q. Do you have an understanding that it does take a period of time?
A. Yes.
Q. Okay.
Because of that, it -- strike that. Because of the fact that it takes some time to begin to hemoconcentrate a patient following the priming with this non-blood fluid, it doesn't surprise you that there would be a drop in hemoglobin and hematocrit, correct?
A. Yes, that's correct.
Q. Once they do get to below 7 like you mentioned, it's your opinion that some additional action needed to be taken, including the transfusion as well as aggressively hemoconcentrating, correct?
A. Correct.
Q. Okay.
Is there anything else that the standard of care required as a result of what you believe to be hemodilution in this case?

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A. I can't think of anything else, no.
Q. Anything else on this Exhibit 2 that causes you concern or that you relate to a violation of the standard of care for Dr. Harrington?
A. No.
Q. Okay.
Obviously again, we've kind of discussed what your interpretation of the radiology is in this case and your review of the neurology consult. But if the cause of this patient's stroke was wholly embolic as opposed to some sort of watershed phenomenon, you would agree that the anemia had no affect on the patient from a damage standpoint?
MR. TAKALA: Objection to form and foundation. But go ahead.
THE WITNESS: I think I know what you are asking. If you pose it that way, that it's wholly embolic, then you are correct. Anemia wouldn't have --
BY MR. THOMAS:
Q. Okay.
In your -- I'm sorry. I didn't

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mean to cut you off.
A. Anemia does not cause an embolic stroke.
Q. Okay.
Maybe that would have been the easier way to ask it instead of something all wordy.
A. That's okay.
Q. In your cardiovascular practice, you recognize that there is a risk of stroke with heart procedures, including valve procedures, correct?
A. Yes.
Q. Do you know what the cited statistics are with respect to risk of stroke for somebody undergoing a mitral valve repair?
A. It's pretty low. Maybe one percent or less.
Q. Do you know what the statistics are for individuals undergoing robotic assisted mitral valve repair?
A. I think they're similar. They're low. Maybe one percent, depending upon other parameters, such as age and other co-morbidities, but it's pretty low.
Q. In this case, Mr. Kostadinovski, did

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he have any co-morbidities or chronic conditions that predisposed him or made him at higher risk for stroke?
A. I think he had some diabetes and he had some type of hypertension and he had age over 65. I think he was 70, wasn't he? And he was a prior smoker. So, some of those factor into the risk calculation.
But I don't think he ever had a prior stroke, and he did have, if I recall, some mild to moderate right-sided carotid disease, if I remember correctly. So, some of those would put him at maybe a slightly high risk.
Q. Let me ask you, you say some of those, diabetes carries with it a risk of stroke, correct?
A. Yes.
Q. Type 2 diabetes puts a patient at a high risk for stroke, correct?
A. Yes.
Q. And that carries on through to people undergoing cardiac surgery or in this case mitral valve repair, correct?
A. Yes. I'll save you time, all of the things I mentioned.

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Q. Thank you. In this case, do you remember Dr. Harrington's testimony with respect to the hemoglobin or the decrease of hemoglobin and hematocrit in this case?
A. In his deposition?
Q. Yes.
A. A little bit. But maybe you could help me, if you could be specific?
Q. Do you remember him --
A. I remember reading through some of the conversation regarding whether or not it was acknowledged to him, the hemoglobin count, and whether or not that was something that was -- that he was made aware of or not. I can't remember exactly what was exchanged, but I think there is some difference of opinion as to whether or not he was made aware.
Q. And maybe that is the best way to put it in this case. Dr. Harrington has indicated that he expects to be notified of any change in the critical values, correct?
A. Yes.
Q. And one of those critical values he indicated, similar to you, was, I think he said, hematocrit under 15 or a hemoglobin under 7,

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correct?
A. Yes.
Q. And it would surprise him and he was surprised -- I don't know if surprised was the same word that he used, but that there was -- he has no recollection of being told in this case that the patient had a decrease of the hemoglobin to 5.1 and hematocrit to 15, correct?
A. That's correct.
Q. And it surprises him, although he wasn't necessarily sure how to interpret the profusion record because he doesn't have a recollection of this patient being transfused, correct?
A. Correct.
Q. Okay.
So, it's not your testimony today and you are not here to tell me that you know what was said to Dr. Harrington during that procedure, correct?
A. That's correct.
Q. It's just your testimony that if he was made aware of the decrease in hemoglobin and hematocrit, then the standard of care required him to transfuse this patient?

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MR. TAKALA: Form and foundation.
BY MR. THOMAS:
Q. Correct?
A. I would say correct.
Q. Have you had patients who have suffered -- I assume that in your years of doing heart surgery and maybe even lung surgery, you have had patients who have suffered strokes?
A. Yes.
Q. And I assume that you have had patients who have suffered embolic strokes as well as, I call them, profusion or this watershed phenomenon, correct?
A. Correct.
Q. Have you in your practice ever seen watershed, this watershed phenomenon, unilaterally, or is it always bilaterally, if you know? Or if you want to defer to somebody else, you certainly can.
A. I can't recall one way or the other.
Q. So, whether or not a watershed phenomenon can present unilaterally, you would refer to a neurologist or neurosurgeon or neuroradiologist?
A. That would be correct.

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Q. Okay.
Have we covered all of your opinions as it relates -- strike that. Have we covered all of your opinions that you believe amount to a criticism of Dr. Harrington for violations of standard of care?
A. Yes.
Q. Are there any other opinions you hold that you intend on providing at the time of trial in this case?
A. Regarding standard of care, no.
Q. Okay.
How often are you doing surgery with a perfusionist?
A. All the time.
Q. I'm kind of reading my notes here. Do you know where it was you last testified at trial, actually at a courthouse?
A. Yes. I think it was the Allentown trial.
Q. Allentown, Pennsylvania?
A. Yes.
Q. In that case, who were you testifying in support of, the surgeon or a plaintiff?
A. In support of the surgeon.

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Q. Do you remember the attorney that retained you in that case?
A. I do not.
Q. Where was his or her office located, if you know?
A. I think it may have been in the Allentown area.
Q. Okay.
A. But I'm not sure.
Q. What hospital was the surgeon affiliated with?
A. Lehigh Valley.
Q. Do you remember what the allegations in that case were?
A. I believe it had to do with a postoperative bleed. Yes, it was. It was a postoperative bleed and the patient had to be rushed back to the operating room to fix a bypass graph that had leaked or disrupted from the connection to the heart and required repair.
Q. Your CV, did I -- I got it.
MR. THOMAS: Tim, I think I'm just about done.
(Discussion off the record.)
BY MR. THOMAS:

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Q. You are a member of the Society of Thoracic Surgeons?
A. Yes.
Q. Have you attended any of the presentations on robotic mitral valve repair?
A. I'm sure that I have. It's a very technologically interesting part of our field, so I tend to gravitate toward technology, so I definitely would have attended some of the sessions and some of the industry sponsored meetings and talks and things of that nature.
Q. Okay.
I asked you if you knew Dr. J. Michael Smith, and you said no?
A. No.
Q. I'm going to ask you if you recall attending any of his discussions or talks on robotic assisted mitral valve repair?
A. I don't recall attending them, no.
Q. That's the only thing I have, Doctor, is just a follow-up, and I may have asked you this. The literature search you did with respect to the issues in anemia -- let me just -- what would have been your search terms in Pub Med, for instance?

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A. It would have been hemoglobin or hematocrit on cardiopulmonary bypass, probably something general like that. And I would look through what pops up and look at particular titles that are relevant. And from there, once you find one, then it has related articles.
Q. Generally, I know you don't have a specific recollection of any of the literature specifically, but you indicated that you did this general search just to kind of corroborate your opinions in this case. What was it that you learned from these articles about hemoglobin or hematocrit during cardiopulmonary bypass?
A. That a low hemoglobin and hematocrit, and we're talking adults, low being defined as under 21 hematocrit, which would be under 7 hemoglobin, that it is associated with increased adverse events, among which are neurologic.
And also again, nothing new to me, it was just validated by my search. But you also have increase in mortality, length of stay, renal failure, ventilator dependence, a whole host of other organ system besides the brain. Adverse event rates are higher. So, those are the things that I was particularly interested in

validating.
Q. Last question. You would agree that a surgeon can comply with the standard of care, do everything right during a mitral valve repair and a patient can still suffer a stroke, correct?
A. Correct.
MR. THOMAS: All right. That's all the questions. Thanks for your time, Doctor.
THE WITNESS: Thank you.
BY MR. TAKALA:
Q. Dr. Samuels, I have just one follow-up issue, and it's in regards to Mr. Thomas' questioning regarding the perfusionist telling Dr. Harrington about critical lab values. Do you remember that line of questioning?
A. Yes.
Q. Okay.
Do you also have any opinion as to whether the surgeon is required to ensure that there are some sort of policies or procedures or discussion with the perfusionist in place so that the operating surgeon would be made aware of critical lab values such as hemoglobin and

hematocrit?
A. I have an opinion.
Q. What is that opinion?
A. That the surgeon should be made aware and should have processes and procedures in place to be made aware of critical values, among which is hemoglobin and hematocrit.
Q. And is that because the surgeon has an obligation to act, as you've told Mr. Thomas, to transfuse the patient when the laboratory values reach those critical levels?
A. Yes.
MR. TAKALA: That's all I have.
MR. THOMAS: I'm thinking. I don't have anything else.
(Witness excused.)
(Deposition concluded at 12:15 p.m.)

CERTIFICATION

I, MAUREEN WALKER, Professional Court Reporter and Notary Public, do hereby certify that the foregoing is a true and accurate transcript of the stenographic notes taken by me in the aforementioned matter.

DATED: February 5, 2015

MAUREEN WALKER

EXHIBIT 7

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

- -x

DRAGO KOSTADINOVSKI AND BLAGA KOSTADINOVSKI, AS HUSBAND AND WIFE,

Plaintiffs,

vs.

Case No. 14-2247-NH

STEVEN D. HARRINGTON, M.D. AND ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.,

Defendants.

- -x

DEPOSITION of THOMAS P. NAIDICH, M.D., taken by Defendants at the offices of Fink & Carney Reporting and Video Services, 39 West 37th Street, Sixth Floor, New York, New York 10018, on Monday, February 1, 2016, commencing at 4:30 o'clock a.m., before Tina DeRosa, a Shorthand (Stenotype) Reporter and Notary Public within and for the State of New York.

APPEARANCES:

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BY: MATTHEW J. THOMAS, Esq.

Naidich, M.D.

(Before the deposition commenced, the following exhibits were marked:

(Fee schedule was marked as Deposition Exhibit No. 1 for identification, as of this date.)

(Curriculum vitae was marked as Deposition Exhibit No. 2 for identification, as of this date.)

(Deposition and trial testimony list was marked as Deposition Exhibit No. 3 for identification, as of this date.)

(Handwritten notes were marked as Deposition Exhibit No. 4 for identification, as of this date.)

THOMAS P. NAIDICH, M.D., called as a witness, having been first duly sworn by Tina DeRosa, a Notary Public within and for the State of New York, was examined and testified as follows:

MR. THOMAS: Let the record reflect that this is the deposition of Thomas Naidich, M.D. taken pursuant to

Naidich, M.D.

Notice and upon agreement of counsel and may be used for impeachment purposes only at the time of trial.

EXAMINATION

BY MR. THOMAS:

Q Dr. Naidich, my name is Matt Thomas. I introduced myself before we got started today I represent Dr. Harrington in the medical malpractice lawsuit that was filed by the Kostadinovskis.

It's my understanding that you have agreed to be an expert on behalf of the Plaintiffs in this case; is that fair?

A Yes.

Q Okay And you have had your deposition taken in the past; correct, sir?

A That is correct.

Q Okay. You were kind enough to provide me a copy of a number of things that are your materials in this case that I have gone ahead and marked some of them as exhibits and I'm just going to briefly go through them.

Exhibit No. 1, I'm going to show that to you and could you just describe for the

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record what that is?

A Exhibit 1 is my fee schedule. This is the fee schedule for the last 15 years. I have just recently increased it, but will maintain this schedule for a case that I have already started.

Q Thank you. And just briefly you charge present $800 an hour for reviewing images studies and related materials; correct?

A Correct.

Q And again in this case $800 per hour for conferences either by phone or in person; correct?

A Correct.

Q And depositions also, are also $800 an hour with a two-hour minimum?

A Yes.

Q Okay. And it's my understanding that my office has sent you a check and you have received that.

A Actually, I think so. I think my secretary said something around that.

Q If for some reason there is an issue with that just let Mr. Meyers know and he'll track me down.

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You charge $8,000 a day for trial outside the Greater New York area?

A Yes, but almost always it's a day and a half minimum to go in the evening before, work with the attorney, testify and then get home.

Q Sure.

A Once in a great while a judge holds you over for something, then I have to charge more, but that's rare.

Q And I have marked as Exhibit No. 2 a copy of your CV?

A Correct. That's current as of November, 2015.

Q Any major updates since November, 2015?

A I just spent the last weekend in Chicago teaching two full days of neuroradiology to neurosurgeons in the Board review case, Board review course run by the Chicago review course.

Q Okay. Just briefly, Doctor, you went to medical school at New York University School of Medicine?

A Correct.

Q And then afterwards you did an

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internship?

A In straight medicine at Bronx Municipal Hospital Center.

Q Thank you. Then you did a residency in diagnostic radiology?

A At Montefiore Hospital Medical Center, then arguably one of best in the country.

Q Then you performed your fellowship in neuroradiology at NYU; correct?

A Correct.

Q Okay. You are Board-certified in diagnostic radiology and you hold a certificate of added qualifications in neuroradiology?

A I do.

Q Do you have any other specialties?

A No, not in terms of national Board recognitions.

Q Do you do any type of interventional radiology?

A Not at this time. I used to.

Q And how many clinical hours are you working nowadays?

A 7:00 in the morning to 9:00 or 10:00 p.m. every day.

Naidich, M.D.

Q And that's how many days a week?

A Seven.

Q And where is the majority of your clinical time spent?

A All my clinical time is at Mount Sinai Medical Center in New York. That is one of the five major teaching hospitals in New York.

Q Okay. And when you're at Mount Sinai from 7:00 a.m. until 9:00 or 10:00 p.m. seven days a week, is the vast majority of your clinical time spent in neuroradiology?

A Yes, almost exclusively. Once in a great while someone, I'm around and they ask me to look at something else. But I am a neuroradiologist at a hospital that has specialized subareas of neuroradiology.

Q Have your credentials ever been subject to any type of discipline or have they been curtailed in any way?

A No.

Q Okay. Isn't it horrible, I forgot what my last question was. I know it was something about being curtailed. Was it your licensure?

Naidich, M.D.

A Okay. No license has ever been questioned or in any way impeded, whatever the words are.

Q Sure. How about your credentials in any way?

A No.

Q If you don't mind I'm going to staple what is marked as Exhibit No. 3 which is your deposition and trial testimony list which you were kind enough to provide, and I think you indicated before we got started this is current through sometime in 2013; correct?

A That's right. I just haven't updated it. The very early parts are a little less accurate because it was made retrospectively. It should be increasingly correct as it gets more recent.

Q All right. And you created this list I presume for some testimony that you were giving in a Federal court case?

A Yes.

Q Just looking --

A And just to tell you D is deposition, T is trial.

Naidich, M.D.

Q Thank you.
You have been retained by Mr. Meyers' office in the past; correct?
A That's correct.
Q Do you know how many occasions total?
A Perhaps ten cases over the last 15 plus years.
Q Okay. Do you know how it is Mr. Meyers learned of your availability to act as expert?
A I no longer remember.
Q Okay. I see that you also list Tanoury, Nauts law firm in Detroit.
You have been retained by them to give deposition testimony?
A Yes. That is correct.
Q And I noticed on this little sheet of paper we have Dave Nauts, Dave Nauts is his last name. Corbet, I assume that is Dan Corbet and Lisa McIntyre?
A Yes. Those are other defense firms which I have been associated over the years.
Q How many times do you think you

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worked with the Tanoury firm, if you know?
A Something like a handful of cases.
Q Okay. And then how about Mr. Corbet's firm?
A I don't remember.
Q Okay. And Lisa McIntyre I believe is of counsel now to the Tanoury firm.
A A couple of cases.
Q Do you know if you have reviewed any cases for any other defense firms in the State of Michigan?
A I probably have, but I don't know now.
Q You have been retained by the Thurswell firm in the past?
A I have.
Q Do you know how many times you have reviewed for Mr. Thurswell's office?
A About a dozen or so.
Q Okay. And I know this is only current through 2013, but approximately how many open files do you currently have?
A I hesitate in answering because I often discover something settled and nobody told

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me.
Q Sure.
A I'm trying to give you what you are asking. I look at 50 to a hundred new patients a year. Many of them never become cases.
I do about 20 depositions a year, but fewer last year. I'm revising a book and that takes time. And I typically do something like three trials a year, but I think there was only one last year for the same reason.
Q When you say 50 to a hundred new patients, those are cases that have been referred to you to review imaging studies or the like?
A Yes, exactly. But often enough I find reason that it's not a valid case and everyone seems grateful not to embark on something that isn't going to be effective.
Q For how long have you been doing 50 to a hundred new cases a year, whether it's just a single review and then the case goes away or whether it goes all the way through trial?
A Probably for the last ten years.
Q What percentage of your income is derived from expert reviews?

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A It peaked at something like 40 plus percent. It's probably down towards the 30's for that same reason. I just haven't been accepting cases while I'm trying to finish this book.
Q Are you affiliated with any type of expert referral service?
A No.
Q Just word of mouth?
A Yes. Once in a while I have been bamboozled and it turned out to be an expert service and then I dropped them.
Q Do you know how many states you have offered testimony in?
A Hopefully the majority.
Q Okay. Where does the vast majority of your cases come from?
A They truly are a national practice.
Q Okay. I presume that you wrote Mr. Nauts', Mr. Corbet's, and Ms. McIntyre's names on this just so you would recall defense attorneys that you reviewed for in the Detroit area?
A That is exactly right.
Q You have been deposed by Mr. Tanoury's office on occasion as well; correct?

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A That's correct. I will say I have a very great respect for Mr. Tanoury.

Q He's a good lawyer.

A More important, one day he visited me and he brought a full check for a deposition and other work I had forgotten I had done and he just brought the income.

Q That's good. That's good to know. All right. You as part of your file materials I see records from Henry Ford Macomb Hospital which include the discharge summary, the history and physical, my client's operative note, and those are all things that you reviewed?

A That's correct.

Q Okay. I also see pages, a three-page document, Pages 1 of 3, 2 of 3, and 3 of 3 that are handwritten notes.

Are these your handwritten notes?

A Correct.

Q I have gone ahead and marked them as Exhibit 4.

A Okay.

Q And we will talk about them in a moment. I'm trying to keep everything in order

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for you.

There was just an enclosure letter from Mr. Meyers' office dated January 15, 2016 where it was indicated that you were provided five medical record binders as well as nine disks containing radiographic studies and you received those?

A I did and I thinned them to something useful.

Q Okay. Those five record binders to the best of your recollection contain records from Henry Ford Macomb Hospital; correct?

A As far as I remember. There was a big box.

Q And I have seen those five binders in other deposition and that's what was contained in those, so I presume it was the same. You don't recall reviewing records from any other treater or provider; is that fair?

A I do not.

Q Okay. And I presume that the vast majority of those five binders were not relevant to your review and, therefore, you were able to pare it down to things that you believe were

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useful; correct?

A That's correct.

Q Also included in your materials here we have the vascular report that was performed in August of 2011. You reviewed that?

A I did.

Q And I see some highlighting. Is that your highlighting?

A Yes.

Q Okay. And then stapled together we have the CT head without contrast dated December 15, 2011. Another CT head without contrast dated December 16, 2011. And there is also included a CT of the spine in that examination.

There is a CT of the head without contrast dated December 17, 2011. Another CT of the head without contrast dated December 19, 2011, and an MRI brain without contrast dated 12/27/2011.

I presume you looked at all of those images?

A That's correct.

Q Okay.

A I did review the cervical spine. I

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don't think it's relevant, but I have reviewed it.

Q I know you were provided a number of disks and you have only the disks that you believe contain the relevant studies with you today; correct?

A I have with me the disks that have the neuroimaging studies. There are chest and other things on other disks. I did not review them.

Q And when we talk about the neuroimaging we are referring to the CT's of the head; correct?

A CT and MR of the brain.

Q Okay.

A And the vasculature.

Q All right. There are some handwritten notes, for instance, on the CT of the head without contrast the radiologist's report, Dr. Randazo's report from 2/15/11. Is that your handwriting?

A Yes. To make it simple for you.

Q Okay.

A I just put the order of the study, what it was, the date and the time of the study so

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I could speak more freely and keep the record straight.

Q Very good.

A And that's on each of them.

Q So when I see 1754 that refers to --

A The hour at which it was begun.

Now, other records may show different numbers. Some record when the patient arrives, some when the exam is finished, et cetera. That is alphanumeric from the study on the first image of the study.

Q So you didn't take those necessarily from the reports. You took them from the studies?

A I took them right from the studies.

Q Okay. Other than your handwritten notes here that we've marked as Exhibit No. 4, have you authored any other type of report or have you authored an actual, like a formal radiology read of the study?

A No, I was not asked to and did not prepare any formal document.

Q Okay. Very good. Doctor, as laborious as this might be, I'm going to ask you if you could just slowly read into the record,

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it's not a lot of information, some of the things are, I noticed on Page 3 of the notes there are some diagrams that you have drawn in. But just so I go back I have idea what that says. Your writing is not terrible, but there are still some things in there that I may not understand. So if you use an abbreviation if you could tell me what that abbreviation is.

A I will read it out without the abbreviations.

Q Thank you.

A The pages are numbered 1/3, 2/3, 3/3 in chronological order of the studies.

Q Thank you.

A And it's labeled Kostadinovski at the top.

One, non-contrast CT of the head 12/15/11 at 1754 hours. Big lucent mass right anterior cerebral artery, gyrus rectus to precuneus/POS, parietal occipital sulcus. Watershed, inferior posterior temporal. Lots of MCA middle cerebral territory blurred. No bleed. Left side looks better, okay. Posterior fossa looks okay. There will be some changes there.

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And question early right caudate. There is a defect in the right caudate. I question only whether I see it on the first study. I clearly see it on the next line.

Line 2. Non-contrast CT head 12/16/15, 1557 hours, ditto darker. More ACA-MCA territory, anterior, more mass effect. Early right caudate.

Line 3, non-contrast CT head 12/17/15 at 1435 hours. Increased mass. Increased definition (of infarct) early right caudate.

Line 4, non-contrast C spine, and I won't write that because the C spine is not relevant.

Q Okay. So that has no relevancy to your opinions; is that correct?

A That's correct.

Q Okay.

A Page 2. And it says D2, meaning Disk 2. Non-contrast CT of the head 12/19/11, 1329 hours. See older dark ACA A-M watershed posterior temporal middle cerebral artery. C different brighter more extensive right middle

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cerebral artery. C, caudate, nucleus.

Backwards E is the math symbol for there exists. There exists one line of increased density in the right pre-central sulcus. There is a line I can't read. Left okay. Next line.

Q Was that left okay?

A Yes.

Q Okay.

A Disk 2, MR head 12/27/11, 2307 hours. Decreased mass. FLAIR positive. Diffusion weighted imaging positive. Original area not the same anymore. DVA, developmental venous anomaly. Axial T1 FLAIR, Series 8, Image 23. Small lacune on the lateral border of the right anterior caudate body. S8 for Series 8. Image 17 and a little diagram of that. A little diagram of a small right cerebellar infarct.

DWI, diffusion weighted imaging positive. Lateral temporal lobe. AMP, anterior/middle/posterior, watershed and posterior temporal. There exists flow voids equal dots in the M2 on the left, but, quote, there exists no flow void dots in M2 on the right. (Not written, but M2 is the second segment of the middle

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cerebral artery). Patchy MCA involvement. Page 3 out of 3. MR brain 3/14/13. T2 FLAIR Series 601, has bad anterior plus middle cerebral artery watershed. Anterior cerebral to posterior occipital sulcus involvement. Abnormal T2 signal intensity in the white matter. Dots of abnormal signal in the contralateral left side. Watershed by diagram. Wallerian stands for wallerian degeneration, a secondary dying off of the white matter fibers after injury. MRA neck 3/14/13. There is a difference between the right and the left internal carotid arteries. The right common carotid is a little bit narrow.

Q Which side, I'm sorry, Doctor?

A Right.

Q Right.

A And I make note that the studies that you have in that pile show that there was a larger stenosis on the right than the left side. Right here.

Q That's the vascular study you're referring to from August of 2011?

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A Yes. It says at the bottom Page 211 if that helps. Interpretation summary at the very bottom. There is 40 to 59 percent stenosis in the right internal carotid artery. Plaque is homogenous. Page 212. There is less than 40 percent stenosis in the left internal carotid artery, signed by a Dr. Youssef Rizk, R-I-Z-K. So there is clearly evidence of narrower right than left carotid. That's it, sir.

Q Okay.

A Oh, I'm sorry, there are a few numbers there measuring the third ventricle on each of the studies.

Q Thank you. So the MRA of the carotids from March of 2013, would you characterize the stenosis significant on either side?

A The left, no. The right, it depends on circumstances. There is a difference and I would defer to the clinicians as to how significant it is, but from my own experience there are cases in which a difference in a critical time may result in differential effects

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in the brain.

Q Would you characterize, we just read that vascular report from August of 2011 and they talk about 40 to 59 percent stenosis in the right internal carotid and less than 40 percent stenosis in the left internal carotid.

Do you believe that is consistent with the MRA from March of 2013?

A There's a difference on both and I didn't actually compare the one to the other.

I only point out that there is a narrower right or whatever that may be used in understanding what happened.

Q Okay. You indicated that, I don't remember your exact words, something about the clinicians that were involved in the time and what they considered to be significant or not.

A Yes. They are the clinicians. I defer to them for the significance of different physiologic data, but it is of interest to me that the side that is affected severely is the side that has the greater carotid stenosis. It's an observation. Others will interpret it.

Q And I guess my question to you is as

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a neuroradiologist who reviews MR's and MRA's, when you have a patient at the hospital do you make a distinction between the stenosis seen in the internal carotid whether it's mild, moderate, severe, significant. Do you classify it by percentage like they did in the vascular study. How do you do it in your normal practice?

A Typically NASCET criteria.

Q What is the criteria?

A The NASCET criteria was a study done long ago in the '70's I think in which you measure the caliper of the internal carotid artery at a uniform segment distal a to stenosis versus the stenosis and you get a percent of decrease in the diameter of the vessels. The computers can generate those numbers for you at this time. So you didn't have to sit there with calipers.

Q Okay. And tell me what the name of this criteria is again.

A NASCET, I think. North American Symptomatic Carotid Endarterectomy Trial.

Q It was not NASA, N-A-S-A, like I wrote down?

A No. No.

Q Okay. In this case did you take out the calipers to make a determination --

A No.

Q -- as to the significance or the amount of stenosis?

A No. And the significance will be determined by the clinicians. It just is a valid observation that the side at which there is cerebral damage is the side which has a narrow carotid artery and the way that might or might not explain any difference in size I'm not capable of answering. I defer to the others.

Q Okay. And that's going to lead me to my next question or take me into my next set of questions.

As part of your review of the films in this case have you made a determination as to the mechanism of this patient's stroke?

A Within the limits of what I can do I have come to the following conclusions.

Q Yes, sir.

A One, there is absolutely clear unequivocal evidence of the development and evolution of a watershed infarction in the right

cerebral hemisphere involving the anterior cerebral artery-middle cerebral artery and extending back in the white matter.

There is clear anterior cerebral artery infarction extending back to the watershed between the anterior and posterior cerebral arteries in the precuneus, P-R-E-C-U-N-E-U-S.

So there is proof positive in the series of studies that the infarct evolved from the first time it's seen on 12/15/2011 over the series of films as we would expect for an acute infarct.

This is not something that's chronic predating. It's acute as of the first study 12/15/11. We have progressive swelling and mass effect of the combined infarcts over the first few studies and then evolution toward atrophy thereafter.

We have interval increase of the size of the third ventricle indicating volume loss that's more than just the right cerebral hemisphere. There's bilateral volume loss.

Q Let me just --

MR. MEYERS: Please, Matt, let

him finish.

Q I wanted him to repeat what he just said. There was interval increase of --

A I think we're up to the third ventricle. You can write 3V. Over the series of studies indicating bilateral volume loss. There is asymmetric involvement clearly affecting the right cerebral hemisphere more severely, but there is also a change on the left side.

In addition to what I have said so far there is an acute evolving infarct of the right caudate nucleus-striatum, and there is a small old branch vessel of PICA, posterior inferior cerebellar artery in the right cerebellar hemisphere. We have no evidence of hemorrhage.

What I see trying to give an overview is clear cut acute injury to the brain with a large component of watershed injury and clear evolution of that toward chronic atrophy and loss of brain substance that will be severe and permanent.

We have as a part of that further degeneration of the fibers that arise in that area which I characterized as wallerian,

W-A-L-L-E-R-I-A-N, degeneration and I can show you that. That goes from the right hemisphere all the way down the brain stem.

There is no evidence of any other disease. There is no evidence of congenital malformation. There is no evidence of substantial old large infarcts.

Everything that we see here evolving from acute to chronic severe permanent injury is the result of the events for which the study of 12/15/11 is an acute evaluation.

Q Thank you, Doctor. Working backwards a little bit. So there is no evidence of substantial old infarct did you see evidence of chronic changes due to hypertension or anything like that?

A There are some little dots. You know, nothing significant. We're talking about, it might be the equivalent of a couple pencil points in size versus more than half of the hemisphere. No. There is no comparison. The injury here is from the acute events.

Q I got you. I just want to make sure that I understand your opinions.

Have you made a determination or are you deferring to other experts whether or not this, I'm going to call it a stroke which is probably overly generic, but I'm going to call it a stroke.

A Fine.

Q This injury, this acute injury that you described occurred during the perioperative or the postoperative period?

A I will defer to others. I have not evaluated that.

Q Thank you. Do you have an opinion and maybe you just gave it to me and I missed it because I'm not too bright when it comes to these things, but do you have an opinion or would you defer to other experts as to whether or not this was an embolic event versus some other event causing this acute injury?

A I'll take it in two parts.

Q Okay.

A Clear beyond doubt there is a watershed infarction that is a very large part of the injury we see in the right cerebral hemisphere. That I attribute to inadequate oxygen

carrying capacity going to the area last supplied which is the watershed causing an infarct in that watershed.

That is the result of inadequate delivery of oxygen and nutrients to the watershed. Clearly that is in accord with very low oxygen carrying capacity due to very low hematocrit.

We also have involvement of the anterior cerebral artery. That could be from the same cause. I don't quite know how best to characterize that, but the extent of that infarct, the extent of the anterior cerebral artery infarct from frontal to occipital is far, far more, far greater in length an anterior posterior extension than is common for anterior cerebral infarcts. It extends back to involve the watershed between the anterior and posterior cerebral artery.

So I believe that there is some anterior cerebral artery infarction and appended to the back of that is a second zone of watershed infarction which is the interface, the border zone between anterior and posterior cerebral artery territories.

So I see not just one watershed

between the anterior and the middle cerebral, but a second watershed of damage between the anterior and the posterior cerebral along the medial surface of the brain. The precise cause of the anterior cerebral artery I'm not sure.

Q So let me see if --

A I have to just finish.

Q Sure.

A There is also right posterior temporal infarct which I think is watershed between middle and posterior cerebral artery.

Q Between, you said watershed between?

A I'll tell you, but I don't know the order I said them in.

Q That is okay.

A Between the right middle cerebral artery and the right posterior cerebral artery.

Q Thank you.

A There is also a right caudate, C-A-U-D-A-T-E, dash striatum, S-T-R-I-A-T-U-M, infarction which is end territory for lenticulostriate arteries, LSA, and that could be watershed. I'm not sure.

Q Okay. And I don't want to cut you

off, but I want to go over these a little bit. And you said there is definitely this watershed infarction that between the right ACA, right MCA, and right PCA; correct?

A Let me define some terms for you.

Q Sure.

A ACA, anterior cerebral artery.

Q Got you.

A MCA, middle cerebral. PCA, posterior cerebral. The term watershed is a little strange. You have to think backwards. The Rocky Mountains are a watershed between the Columbia and the Mississippi, Missouri water systems. Reverse go upstream.

Q Right.

A The watershed is the border zone between the last areas supplied by one vessel and the last area supplied by the others. It's the interface between the territories and if there is poor oxygen delivery for whatever reason what drops out, well, the last area supplied.

Q So when you are talking about these border zones and I heard what you said you believe that that watershed area, the reason for the

infarct was due to inadequate oxygen capacity, correct, or carrying capacity I suppose?

A Take it in two steps. There is infarcted because there was inadequate supply of oxygen and nutrients.

Q Right. Got you.

A Now, why was there inadequate supply, I'm told by attorneys that there was an event at surgery that would be an adequate explanation for that. I defer to the clinicians to discuss that. But clearly what keeps the brain alive is sugar delivered, glucose and oxygen to burn it. And if you don't have them, you don't have the oxygen, tissue dies.

Q So, and I understand that you are going to defer as to what caused the inadequate but what you're seeing there when we talk about these watershed areas is in your opinion secondary to inadequate oxygenation?

A Yes. Inadequate delivery of enough oxygen and nutrients.

Q Do you have an opinion if it was related to a hypotensive event, a malperfusion event, anemia or would you defer?

A I necessarily defer to the clinicians because they have reviewed those records. What I see is the net effect on the brain.

Q Got you.

A And in truth, so it's clear, I stand by the anatomic pathologic changes. Those I see. Those are inferred by the clinicians for good reason, but I see them and this is what happened.

Q That's fair enough. Now, I want to move on to the second stroke. I had asked you about or you had described to me this infarct that extends from the frontal to the occipital areas.

Do you know if that infarct or do you have an opinion more likely than not that that infarct was caused by a lack of oxygenation or inadequate oxygenation versus some sort of embolic phenomenon?

A Occam's razor says you should try to be simple. The rule of parsimony. One explanation to explain both.

Clearly it could be caused by lack of oxygenation, but I'm not sure. I don't want to state to a reasonable degree of medical

probability that I know for certain what caused the ACA infarct. It's possible it's hypoperfusion. Excuse me, that came out wrong. It's possible it's hypo-oxygenation.

I do say that the ACA infarct we see is elongated by the involvement of the A-P, anterior to posterior cerebral artery watershed. That would have the same cause as the anterior to middle cerebral watershed.

So that the extent of the anterior infarct coming further back than typical is the result of the same problem as caused the very large watershed infarct between anterior and middle.

Q And I appreciate all that. I just want to make sure I understand. The ACA, the anterior cerebral artery infarct, you don't feel comfortable making a statement more likely than not or beyond or within a reasonable degree of medical certainty whether that was due to an embolic event or it was due to a lack of or inadequate oxygenation?

A That's not quite what I said though it's toward the question you asked. I have no

specific evidence here for emboli, period. I have no evidence for emboli.

Q Sure.

A Therefore, what I'm trying to say honestly is I'm not certain what the cause of the anterior cerebral artery infarct is for the front part versus the watershed at the back.

I can understand it as a hypo-oxygenation, but I don't wish to state that I know that it's true for the ACA and again I defer to others who may have a better idea than I do. It's there. It's infarcted. But it has a little different character than the watershed and I'm not certain.

Q Okay. The right posterior temporal infarct that you described, do you have an opinion within a reasonable degree of medical certainty or more probably than not what caused that infarct?

A I think it's watershed between middle and posterior.

Q Secondary to what mechanism, if you know?

A I would postulate the same hypo-oxygenation.

Q Within a reasonable degree of medical certainty?

A I'm not certain. As with the ACA I'm not totally certain of that.

Q And I appreciate that you are not totally certain, Doctor, and, you know, in Michigan I'm sure you heard this before we don't operate in certainties. We operate in more likely than not.

That's what I'm trying to get at, is your testimony at the time of trial of this matter more likely than not that the right posterior temporal infarct was watershed due to hypo-oxygenation or it's just something that you can't say one way or the other?

A The answer to that is I think it is likely it is, but -- I think it's likely that the right posterior temporal infarct is due to hypo-oxygenation, but I cannot state that to a reasonable degree of medical probability.

Q Can you say it more likely than not?

A I'm not certain for that part.

Q Okay.

A I am absolutely certain that the

anterior to middle cerebral is an extensive hypo-oxygenation infarct and the anterior to posterior watershed is also, and the others I'm trying to be very careful in what's said here and I'm not sure.

Q No, and I appreciate that and I appreciate the distinction. I appreciate the points that you are making.

Now, forgive me for being so ignorant because you used when you were reading your notes from Exhibit 4, you used the word caudate.

A Okay. I understand what you're asking. I'll digress for a minute.

Q Sure.

A To a purpose.

Q Okay.

A Reason with me. There is a surface of the brain. The surface of the brain is covered by gray matter. Those are your neurons. That is officially the superficial gray matter also called cortical gray matter and because it's undulant it's often called the cortical ribbon, superficial gray, surface gray, cortical ribbon.

Underneath that is white matter. White matter is divided in three parts from outside toward the subcortical deep white and periventricular white matter.

Next to the ventricles are hunks of gray matter. Those are the deep gray matter. As an umbrella term the deep gray matter is everything deep against the ventricles that's not cortex.

It's divided into many things. In a series of cascades the deep gray is divided first into thalami which are not involved here and the basal ganglia. The umbrella term itself basal ganglia is divided into caudate nucleus, putamen, globus pallidus and some include subthalamic nucleus and amygdala.

So you don't get crazy here, you know what a Venn diagram is.

Q Yes.

A Well, this is double Venn. Term, striatum is caudate plus putamen. Overlapping then with that lenticular nucleus, synonym lentiform nucleus is putamen plus global pallidus. So the striatum is caudate putamen, lenticulus

putamen globus pallidus and they are all part of basal ganglia. That's why they give a medical student a dictionary the first day of school.

Q I should have brought mine today.

The infarction that you described in the right caudate-striatum, do you or will it be your testimony that more likely than not that was watershed due to hypo-oxygenation versus something else or can't you tell?

A I think it's part of the same reduced delivery of oxygen to the tissue.

Q More likely than not?

A Yes. It's an end vessel and I think it just didn't get enough.

Q Now, was that a result of the infarctions in other areas of the brain?

A It has much the same time course. I think it's just another of the events that happened together.

Q Okay. I'm going to try to do a summary real quick and I will get as close to using your words as possible. If I don't please tell me or if I get it wrong please tell me.

So the ACA to MCA to PCA, those

watershed areas, that was the first infarction we discussed. It is your opinion that more likely than not that was due to hypo-oxygenation; correct?

A Yes.

Q Okay. The right caudate-striatum infarction, it is your opinion that more likely than not that that is related to hypo-oxygenation; correct?

A I think so.

Q Okay. The infarct in the anterior cerebral artery, while it could have been from hypo-oxygenation, you cannot say more likely than not that it was; correct?

A Correct.

Q Okay. And similarly the right posterior temporal infarction, while it could have been from hypo-oxygenation, you cannot state more likely than not that it was; correct?

A That's right.

Q Okay.

A And I would like just to add so it's clear, I'm trying to be very careful. I see nothing that is absolutely embolic.

Q Right. You don't see any --

MR. MEYERS: Let him finish, please.

A Everybody is saying that it could be embolic and while that's possible there isn't any evidence on the imaging studies for emboli.

Q Would you agree that most strokes related to cardiac surgery are, in fact, embolic?

A I'm not prepared to answer that.

Q Okay. Do you know what the frequency of stroke is with valve replacement or repair?

A No. It obviously varies with the institution, the type of surgery done and the pump team and individual skill.

Q Okay. Now, I didn't see included in these medical records, the ones that you pooled, the March MR report or the March MRA of the neck. Did you pull the reports for those?

A We have -- we may have to back up to one thing I said.

Q Sure.

A I'm not sure it was done in the same hospital. It's much later and try as we might we

have been unable to get the record.

MR. MEYERS: In fairness to the doctor he requested them a week ago, but we have not been able to get them. We have the images, but not the reports.

MR. THOMAS: And, quite frankly, Jeff, I haven't seen them either. So that's why I was asking.

MR. MEYERS: But in fairness to the doctor he requested them and we have not been able to comply with his request.

MR. THOMAS: Sure. Right.

Q And you've explained to me what you saw on the MR of the brain from March and that's documented here on Page 3 of 3 of your notes?

A Yes. By way of example, not limitation.

Q Sure. And similarly, the MR of the neck from March 14, 2013 you talked about there was some narrowing of the internal carotids; correct?

A Yes. The right lumen is narrowed.

Q The very last line here, Doctor. Mild narrowing ICA. What side is that referring to?

A I'm sorry, if you look, remember this is imaging. This is the right. That's the left.

Q Correct.

A So narrowing is for this one.

Q For the right side?

A For the right side.

Q Okay. And you described it as mild narrowing of the internal carotid; correct?

A That's correct.

Q Okay. I'm going to go back in time through my notes and they are probably going to be hard to decipher, but let me ask you this. Did you see any left-sided hemisphere infarcts?

A There are some changes on the left.

Q I'm going to hand you your Exhibit 4 which are your three pages of the notes. Could you please tell me what you found on the left and what study?

A I'll have to go through all of them. I have in the diagram from 12/27/11 some watershed

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left involvement in the centrum semiovale. And I'll take a moment to just see what I see on these because these are loaded.

Q While you're looking that up may I come around so I can peek over your shoulder, please?

A Sure.

Q Thank you.

A I will go through it with you, but right now I am trying to answer your present question.

Q Please.

A There are some small changes in the left hemisphere in the deep white matter of basically uncertain significance.

Q I'm sorry, I don't want to interrupt.

A On the 15th Series 2, Image 32 shows a small dot in the white matter of the left posterior frontal lobe.

This is seen again in the same area on the study of the --

THE WITNESS: I'm sorry, I said Series 2 what number?

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THE REPORTER: Image 32.

THE WITNESS: Okay. Make it 33, please. Please change that.

A It's seen in the same area on the next day's study, 12/16/11. Series 2, Image 32 and on the study of 12/17 Series 2, Image 34, significance uncertain.

Q Say that again, Doctor.

A The significance of that is uncertain. It is not particularly evolving over those three days.

Q Okay. And just following up on significance uncertain, is it fair to say then whether or not that was an acute finding you can't tell?

A That's correct.

Q Okay. Is it fair to say that the acute findings that you did see were all right-sided?

A That is correct.

Q Do you have an opinion one way or another why if there was watershed, why the stroke was unilateral?

MR. MEYERS: Let me object to

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the form of the question because he has testified that it was watershed, but I don't know if the question reads that way.

Q Let me see if I can fix the question.

You would agree with me that generally when you see watershed it's bilateral; correct?

A That depends on a number of factors. It can be, certainly. There are times where it's unilateral. It depends on blood flow. It depends on differential stenosis. It may depend on patient position. Whether a patient is positioned in a way that there is preferential flow to one side or the another. If a head is kinked in position for some reason. If the neck is bent in a certain way flow could be redirected. Watershed is not necessarily bilateral.

Q Would you agree that the majority of watershed is bilateral that you see?

MR. MEYERS: I object to the form of the question. I think I understand the question, but I object

Naidich, M.D.

to the way it's stated, the form of the question.

Q If you can answer, Doctor.

A Could I ask you to repeat it?

Q Sure. The majority of watershed that you see in your practice, would you agree that it is generally seen or the majority of the watershed that you see is bilateral in nature?

A It certainly may be. It depends on a number of factors. If you're talking as I think you are intending it to be hypotensive, hypo-oxygenation, then, yes, it's usually bilateral. But in the specific circumstances it may be unilateral.

Q In this particular case, do you attribute any particular mechanism to explain why it's unilateral in this case.

Let me strike that question. Let me see if I can make it a little more clear.

You indicated there are certain things that can result in unilateral watershed and blood flow stenosis. Patient position, preferential flow, those type of things.

Do you believe that there was any

particular mechanism in this case that resulted in unilateral watershed as opposed to bilateral watershed?

A I'm not able to address that.

Q Thank you. Would you agree that that the March, 2014 MRA ruled out significant carotid stenosis or would you again defer, leave it up to a clinician as to the significance of it?

A It showed that the left side showed no significant stenosis. I think all agree. The right side had stenosis that most people in usual circumstances would consider it to be not significant, under 60 percent, 40 to 59 percent are quoted.

In critical circumstances where there is a borderline situation of survival or not, the last straw, if you will, to break the camel's back, there are times where a stenosis may result in differential effect in the brain. Here I again defer to the clinicians as to whether that is true in this case.

Q Did you as part of your review in this case take note of Mr. Kostadinovski's risk for stroke due to comorbidities or anything like

that?

A No, but I want the record to be clear. In clinical practice I'm involved with that. In expert witness I try to limit my testimony to my own field feeling that true experts, clinicians, should comment on what they know, I on what I know, and then the data are put together.

I'm not an expert clinician. I don't wish to offer an opinion that is not expert and so it is not for failure to look at the material. It's deliberate election to leave that to true experts.

Q Mr. Meyers was kind enough to tell me before we got started that I could come and sit next to you.

(Discussion off the record.)

Q I was just saying Mr. Meyers was kind enough before we got started today to say I could come over and sit next to you while you went through the films.

I presume that all of your significant findings on the films even though they might not be all inclusive are contained on Pages

1 of 3, 2 of 3, and 3 of 3?

A I will not accept a limitation on what I will show to a jury or what I will state to be significant based on whether or not it happens to be recorded in those notes.

Q Okay. Fair enough. Well, in that case then I guess we are going to sit down and we're going to go series through series and you can tell me everything you see and I don't know if you want to look at your notes while you're doing so.

A Why don't you come. There's a chair there.

MR. MEYERS: Off the record for a minute.

(Discussion off the record.)

MR. MEYERS: Doctor, do you think you have articulated your opinions as to the characterization of the injuries in such a way that a neurologist or neuroradiologist will understand your opinions and be able to relate them to the images that are available for all to see?

THE WITNESS: Yes.

BY MR. THOMAS:

Q Let me just follow-up with a couple of things.

MR. MEYERS: Fine. Do whatever you want to.

MR. THOMAS: No, I know and we seem to work well like that. We're good.

Q And I just want to make sure, Doctor, that you have expressed to me your opinions that you anticipate talking about at the time of trial and you may use various films to explain that to a jury and I don't -- I'm not trying to limit you to what's on those notes, but you have told me about the infarctions that you see?

A Yes. All the opinions I have you have carefully brought out.

Q Okay.

A The exact images are used to exemplify them will depend on whether I make the Power Point and so forth, but the opinions are out there.

The summary opinion is there is evidence of injury to the brain on the first study of the 15th. It is acute at that time.

Q Thank you.

A It evolves thereafter in a way that documents it was acute at that time. It preferentially involves the right cerebral hemisphere.

It has clear watershed components, anterior-middle cerebral artery and anterior-posterior cerebral artery and other elements that may be hypo-oxygenation, but we're not entirely clear as to the mechanism.

Those less clear areas are the anterior cerebral artery on the right and the right posterior temporal.

The right caudate I think is hypo-oxygenation as well. There is no hemorrhage. There is no evidence of any significant preexisting injury.

There are some small little things, but they have no significance compared to what we're talking about now. There is no hematoma. There is evolution to chronicity over the series

which I have documented on my sheet of paper and that includes secondary wallerian degeneration of the brain stem and volume loss in both hemispheres, not just the right.

And the injury that I see from acute through subacute to chronic is severe and will be permanent and involves clear cut loss of brain tissue, brain volume in a way that's not recoverable.

Q Thank you. Is it your intention to offer an opinion as to which infarcts have resulted in which residual injury to Mr. Kostadinovski?

A There is something called plasticity. Plasticity is the concept that when one area of the brain is injured others may at times be successful in taking over that function.

While I can tell you in many cases what function typically resides in an area that is damaged, I cannot tell you in an individual whether plasticity has kicked in and there is or is not functional injury.

For that reason I defer clearly to the neurologists who have examined the function of

the patient to state what functional deficits have resulted.

Q And I appreciate that and just to follow-up, can you state with any medical certainty or within medical probability which infarct that you see is a result -- strike that. Let me see if I can do better.

Can you state with any medical degree of probability which infarct has resulted in his left-sided hemiparesis or is it based on what you just told me, due to plasticity you would defer to a clinician?

A I would defer to the clinicians. I can tell you the watershed is clearly capable of producing a hemiparesis. It involves the white matter through which the corticospinal tracts go. We have wallerian degeneration in those tracts, but there are many differences that a neurologist can parse out which may assist the neurologist in understanding that better.

So I would feel more comfortable in saying the watershed injury I see would be enough, but I would defer to the neurologist to state which is the most probable.

Q Okay. Other than the March, 2013 MR of the brain and the March, 2013 MRA where they looked at the internal carotids, the other studies which you have reviewed the reports are attached?

A They are.

Q To what I'm holding in my hand?

A That's correct.

Q Which is Pages 407, 408, 409, 410, 415, 416, 417, 418, 425 and 426, and I'm just for posterity I'm going to mark that as Exhibit No. 5 and have I done so, Doctor?

(Reports were marked as Deposition Exhibit No. 5 for identification, as of this date.)

A You have.

Q You know what, I'm going to mark our vascular report because you did review that, correct?

A That's correct.

Q As Exhibit 6 and that consists of two pages and have I done so, Doctor?

(Vascular report was marked as Deposition Exhibit No. 6 for identification, as of this date.)

Naidich, M.D.

A You have.

MR. THOMAS: Okay. Doctor, with that that is all the questions I have at this time. Thanks for your time.

THE WITNESS: Thank you.

MR. MEYERS: I'm not going to ask any questions.

(Discussion off the record.)

MR. THOMAS: Let's mark these also.

(Handwritten notes was marked as Deposition Exhibit No. 7 for identification, as of this date.)

(Invoice was marked as Deposition Exhibit No. 8 for identification, as of this date.)

(Invoice was marked as Deposition Exhibit No. 9 for identification, as of this date.)

(Whereupon, at 5:40 o'clock p.m., the deposition was concluded.)

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EXHIBITS

CERTIFICATE

STATE OF NEW YORK)
) ss.
COUNTY OF NEW YORK)

I, TINA DeROSA, a Shorthand (Stenotype) Reporter and Notary Public of the State of New York, do hereby certify that the foregoing Deposition, of the witness, THOMAS P. NAIDICH, M.D., taken at the time and place aforesaid, is a true and correct transcription of my shorthand notes.

I further certify that I am neither counsel for nor related to any party to said action, nor in any wise interested in the result or outcome thereof.

IN WITNESS WHEREOF, I have hereunto set my hand this 4th day of February, 2016.

TINA DeROSA

EXHIBIT 8

STATE OF MICHIGAN

61524

IN THE CIRCUIT COURT FOR THE COUNTY OF MACOMB

DRAGO KOSTADINOVSKI and BLAGA KOSTADINOVSKI, as Husband and Wife,

Plaintiffs,

v.

Case No. 14-2247-NH
Hon. Kathryn A. Viviano

STEVEN D. HARRINGTON, M.D., and ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

Defendants.

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PLAINTIFFS' FIRST AMENDED COMPLAINT AND RELIANCE ON PREVIOUS DEMAND FOR JURY TRIAL

NOW COMES Plaintiff herein, Drago Kostadinovski and Blaga Kostadinovski, as Husband and Wife, by and through their attorneys, MORGAN & MEYERS, PLC, and states as their cause of action against the above-named Defendants the following:

1. The amount in controversy is in excess of TWENTY FIVE THOUSAND ($25,000) DOLLARS.

2. At all times pertinent to this Complaint, Drago Kostadinovski (hereinafter "Mr. Kostadinovski") was a resident of the County of Macomb, State of Michigan.

3. At all times pertinent to this Complaint, Blaga Kostadinovski (hereinafter "Mrs. Kostadinovski") was a resident of the County of Macomb, State of Michigan.

4. At all times pertinent to this Complaint, Steven D. Harrington, M.D. was a physician doing business in the County of Macomb, State of Michigan.

5. At all times pertinent to this Complaint, Advanced Cardiothoracic Surgeons, PLLC was a Michigan Limited Liability Company doing business in the County of Macomb, State of Michigan.

6. At all times pertinent to this Complaint, Dr. Harrington was an employee/agent at Advanced Cardiothoracic Surgeons P.L.L.C.

7. In paragraphs 8 – 69 as set forth below, Plaintiffs make reference to statements contained in the medical records of various health care providers. The recitation of these factual statements should not be interpreted as an admission by Plaintiffs as to the factual authenticity or truthfulness of these statements. The statements are set forth below to provide context as to the violations of the standards of care, also described below.

8. Prior to the events described in this Complaint, Mr. Kostadinovski was a married man who was able to perform all of his activities of daily living independently as well as mobilize independently.

9. Prior to the events described in this Complaint, Mr. Kostadinovski was able to care for himself independently while living with his wife.

10. On July 30th, 2011, Drago Kostadinovski, a 70-year old male, date of birth, May 10th, 1941, presented to the Henry Ford Macomb Hospital Emergency Department stating that he had just completed an echocardiogram at the Henry Ford Out-Patient Clinic located at Fifteen Mile Road and Ryan.

11. While at the clinic, Mr. Kostadinovski had informed the staff that he was having a hard time breathing and at times was having difficulty swallowing pills and drinking water.

12. Mr. Kostadinovski indicated that the staff at the Henry Ford Clinic sent him to the Emergency Department for further examination. Upon arrival at the Henry Ford Macomb Hospital Emergency Department, Mr. Kostadinovski was seen by Arti Bajpai, M.D. and Patrician L. Milani, MD who indicated that the Mr. Kostadinovski presented with difficulty breathing and was unable to breathe at times during the night. These symptoms began approximately three days prior to the July 30th, 2011 admission and fluctuated in intensity.

13. Mr. Kostadinovski's medical history included hypertension, hyperlipidemia, diabetes and a social history of tobacco smoking, noting that Mr.Kostadinovski had quit tobacco one year ago. The impression of the ER physicians was dyspnea, with a plan to rule out cardiac causes, including myocardial infarction, angina, CHF. It was noted that Dr. Milani had discussed the case with Dr. Abas Jafri, Mr. Kostadinovski's primary care physician.

14. After Mr. Kostadinovski was examined in the Emergency Department, he was admitted to the in-patient telemetry unit and his care was transitioned to Maria B. Perry, M.D.

15. On August 1st, 2011, Mr. Kostadinovski underwent an echocardiogram for the clinical indication of CHF. The ordering physician was noted as Marius Laurinaitis, MD. The interpretation included demonstration of right ventricle with normal size and function. Left ventricle size, thickness and function were normal. The left ventricular ejection

fraction was normal. The mitral leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with a moderate mitral regurgitation, and posterior mitral leaflet changes consistent with mitral prolapse and some mal opposition with moderate to severe MR.

16. Following the results of the echocardiogram, a transesophageal echocardiogram was recommended and performed in a two-dimensional fashion.

17. Again, the mitral valve leaflets appeared thickened, hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation.

18. A duplex extra cranial artery study was performed, which indicated 40 to 59 percent stenosis in the right internal carotid artery with homogenous plaque found. Less than 40 percent stenosis was noted in the left internal carotid artery. The study was interpreted by Rizk Youssef, D.O.

19. On August 3rd, 2011, under the attending care of Dr. Perry, and by order of Dr. Majid Al-Zagoum, Mr. Kostadinovski underwent a persantine myocardial perfusion scan with a noted history of chest pain, hypertension, diabetes and hypercholesterolemia. The report was read by Khurram Rashid, M.D., with an impression noting no scintigraphic evidence of reversible ischemia and with normal left ventricular wall motion and an ejection fraction of 69 percent.

20. On August 3rd, 2011, an exercise stress test was performed and interpreted by Durgadas Narla, M.D. The impression was negative per statin stress EKG, with occasional PBCs, stable vital signs which correlated with the myocardial scan report.

21. On August 4th, 2011, another two-dimensional transesophageal echocardiogram was performed. It was performed under the order of Dr. Al-Zagoum and

interpreted by Dr. Al-Zagoum with an interpretation of moderate to severe mitral regurgitation. The mitral regurgitant jet was noted to be eccentrically directed. Prolapse of the anterior mitral leaflet ejection fraction was noted at 60 to 65 percent.

22. On August 5th, 2011, Dr. Perry requested a consultation by Steven D. Harrington, M.D. The reason for the consultation was mitral insufficiency and dyspnea with exertion.

23. In Dr. Harrington's consultation note, Dr. Harrington noted the history of the present illness as a 70-year old male who speaks limited English, originally from Macedonia.

24. Dr. Harrington indicated that his son-in-law was at bedside and translated the conversation. Mr. Kostadinovski reported that he had been having increased shortness of breath and reported episodes of dyspnea while lying flat. He also reported episodes of reflux for the past several days; however, he denied any other accompanying symptoms.

25. Dr. Harrington's assessment of Mr. Kostadinovski at the date of the consultation was: (1) acute exacerbation of congestive heart failure secondary to mitral regurgitation; (2), status post-echocardiogram, no current TEE report is in the chart; however TD echocardiogram revealed the mitral valve leaflets to be thickened with hooded and/or consistent with myxomatous degeneration with moderate mitral regurgitation. Ejection fraction was estimated at 55 to 60 percent, three negative persantine stress EKG, 40 to 59 percent stenosis to the right internal carotid artery and less than 40 percent stenosis to the left internal carotid artery.

26. Dr. Harrington's plan was to order a transesophageal echocardiogram report which would be reviewed by Dr. Harrington. Dr. Harrington noted that Mr. Kostadinovski would need cardiac catheterization prior to a mitral valve repair/replacement. The cardiac catheterization would be to rule out coronary artery disease and the possible need for myocardial revascularization, as well as mitral valve repair/replacement. The note was dictated by Ryan Ramales, Physician's Assistant and was approved by Dr. Harrington on August 7th, 2011.

27. On August 4th, 2011, Mr. Kostadinovski was discharged from Henry Ford Macomb Hospital, noting that at 2D echo was suggestive of severe mitral valve insufficiency and was confirmed by transesophageal echocardiogram. The discharge summary included an evaluation by Dr. Harrington in the Cardiovascular Surgery Department and that out-patient follow-up was recommended. Mr. Kostadinovski was to follow up with Dr. Jafari in three to four days, to follow up with Dr. Al-Zagoum in five to seven days and to follow up with Dr. Harrington in ten to 14 days.

28. On September 12, 2011, Mr. Kostadinovski underwent cardiac catheterization at the Cardiac Catheterization Laboratory at Henry Ford Macomb Hospital. The cardiac catheterization was performed and reported by Dr. Al-Zagoum. Findings were noted as a normal left main coronary artery. "Left anterior descending artery has one major diagonal branch which appeared to be normal and the left anterior descending itself appeared to be within normal limits. The left circumflex artery had one major obtuse marginal artery branch which appeared to be normal and the right coronary artery was a dominant artery with no significant disease noted." Left ventriculography was done using pigtail catheter with ejection fraction about 35 to 40 percent with global hypokinesia.

29. On December 9th, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital under the care of Dr. Steven D. Harrington for a pre-surgical evaluation for mitral valve repair/replacement with robotic assistance.

30. During this consultation report, Dr. Harrington noted the September 12, 2011 cardiac catheterization by Dr. Al-Zagoum, in which Mr. Kostadinovski was found to have normal coronary arteries and moderate left ventricular dysfunction. The ejection fraction was noted to be between 35 and 40 percent, and at that point, Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

31. An x-ray of the chest was performed on this date with a clinical history of "some difficulty in breathing/pre-operative study", which demonstrated no significant interval change from the prior x-ray which was performed on July 30, 2011.

32. No CT study of the chest, nor any CT angiogram was ordered or reviewed by Dr. Harrington on December 9, 2011 on the pre-surgical clearance admission, nor was any CT study or CT angiogram ordered and reviewed prior to the DaVinci mitral valve repair surgery on December 14, 2011.

33. On December 9, 2011, Dr. Harrington's assessment was mitral insufficiency with normal coronary arteries and diabetes myelitis type II. As far as prior testing, Dr. Harrington reported that on August 8th, 2011, Mr. Kostadinovski underwent a transesophageal echocardiogram which revealed severe mitral valve prolapse, prolapse of the anterior mitral leaflet with moderate to severe mitral regurgitation, and also noted that the tricuspid valve was normal and had mild tricuspid regurgitation.

34. On December 9, 2011, Dr. Harrington did not recommend nor order that Mr. Kostadinovski undergo any further echocardiogram testing, CTA or other angiogram

studies to determine any extent of atherosclerotic process or atherosclerosis in the aortic arch at this time. Informed consent was reported to be given after risks were discussed, and Mr. Kostadinovski was scheduled for surgery on December 14, 2011.

35. On December 14, 2011, Mr. Kostadinovski presented to Henry Ford Macomb Hospital for a DaVinici mitral valve complex repair with posterior leaflet resection and 28-millimeter, CG future band annuloplasty and ligation of left atrial appendage.

36. The operation was performed by Steven D. Harrington, M.D. with the assistance of Shelly Klein, PA-C. Anesthesiology was performed by Dr. Zhang, who also performed a transesophageal echocardiogram (TEE), which was noted independently, as performed by anesthesia, although the body of the operative report indicates that Dr. Harrington interpreted and utilized the data from the intra-operative TEE study.

37. In the operative findings, Dr. Harrington noted that there was severe mitral insufficiency with torn P2 posterior segment allowing prolapse of both anterior and posterior leaflets.

38. Dr. Harrington indicated that the repair had been accomplished with quadrangular resection of the P2 segment, primary repair, and a 28 millimeter CG future band angioplasty.

39. Dr. Harrington indicated that Mr. Kostadinovski was in normal sinus rhythm pre-operatively and post-operatively and had "excellent" left ventricle function. Dr. Harrington further noted that post-operative repair showed no mitral insufficiency and no evidence of mitral stenosis.

40. During the procedure, Mr. Kostadinovski was placed in the supine position, prepared and draped in a sterile fashion and the right groin was opened, exposing the

femoral artery and vein, and the was cannulated with a 23 arterial hemostatic valve catheter and a 25 venous Heart Port catheter in the vein, all positioned with transesophageal echo guidance.

41. At this point, the DaVinci robot was brought into position and docked and the EndoAortic clamp was brought into position with transesophageal echo guidance.

42. Cardiopulmonary bypass was instituted and the EndoAortic clamp was inflated and the heart was arrested with administration of HTK cardioplegia injected into the aortic root. With the robot, the diaphragmatic stitch retraction was placed followed by opening the pericardium on and pericardial traction sutures.

43. At that point, Dr. Harrington noted the inter-arterial groove was then developed and opened and left atrial retractor placed exposing the valve. Dr. Harrington noted "obvious P2 segment that was torn and that was resected with quadrangular resection and repaired with a primary repair with No. 4 Gortex suture."

44. After further repair, the valve was tested to see that it was secured and it was with no leak after injection of 250 milliliters of saline. The EndoAortic clamp was released and the patient returned spontaneously to a sinus rhythm.

45. During the operation Mr. Kostadinovski's perfusion was monitored by Lynn Masinick and reported to Steven Harrington, MD

46. During the operation, Dr. Harrington failed to appreciate Mr. Kostadinovski's hypotensive status and transfuse the patient.

47. Dr. Harrington noted adequate rewarming and reperfusion and a weaning from cardiopulmonary bypass and decannulization without difficulty, requiring no inotropes,

only a small amount of neo-synephrine, which was quickly weaned off. After the operation, Mr. Kostadinovski was transferred to the Intensive Care Unit for recovery.

48. Dr. Harrington noted that a peri-operative transesophageal echocardiogram showed excellent cooptation of leaflets, no mitral insufficiency, normal sinus rhythm, and stable left ventricular function.

49. Upon transfer to the Intensive Care Unit, Mr. Kostadinovski's post-operative vital signs were recorded as follows: temperature 101.9 axillary, pulse 86, respirations 10, blood pressure 134/55, and O_2 sat a hundred percent on FI O_2 of 40 percent.

50. It was noted that Mr. Kostadinovski did not awaken post-operatively, and on December 15th, at 01:15 a.m., the nursing staff noted the presence of tonic-clonic movements lasting approximately 65 seconds. At that time, Mr. Kostadinovski remained unresponsive, despite attempts to stimulate him. He did not open his eyes or follow commands.

51. It was also noted during the night of December 15, 2011, that Mr. Kostadinovski had 15 seconds of involuntary movements involving the left-side of his face and his eyes, prompting the administration of Keppra 500 milligrams, IV piggyback and Ativan, 2 milligrams, IV.

52. Rajindar K. Sikand, M.D. was consulted who formulated a plan to rule out anesthesia versus neurological event post-op after being called to consult a non-responsive patient who was unable to follow commands and noted to be lethargic occurring overnight on the first day post-op.

53. On December 15, 2011, at approximately 14:00 hours, it was noted that medical staff had witnessed spontaneous movement of Mr. Kostadinovski's right arm, after

he grasped on two occasions with his left hand and nursing staff noted some tremors in Mr. Kostadinovski's "saddle region." At that point, Dr. Wilma E. Agnello-Dimitrijevic, M.D., a neurologist, was consulted regarding Mr. Kostadinovski's condition.

54. Dr. Agnello-Dimitrijevic noted at that time that Mr. Kostadinovski did not have a history of TIA stroke, seizure or syncope, and no known history of neuropathy or retinopathy.

55. On December 15, 2011, a CT of the brain was performed without contrast, and it was reported as demonstrating evidence of acute ischemic infarct within the right cerebral hemisphere, having the appearance of water shed distribution involving the right anterior cerebral artery distribution. There was no noted evidence of hemorrhage. That study was interpreted by Frank Randazzo, M.D., and it was also noted in the consultation note that Dr. Agnello-Dimitrijevic also interpreted the study and noted evidence of extensive sulcal effacement involving the right front temporal and parietal lobe, consistent with infarction, most notably in the ACA territory. There is also evidence of involvement of the MCA territory. There was no evidence of midline shift and no evidence of hemorrhage. No obvious sulcal effacement is noted in the left hemisphere.

56. An electroencephalogram (EEG) was performed on December 16, 2011 to rule out seizure. The impression of the reviewing physician, Dr. Shyam Moudgil, M.D. indicated the impression of an abnormal EEG, suggestive of diffuse cortical neuronal dysfunction, as seen in moderate encephalopathy and clinical correlation as to the etiology of the encephalopathy was recommended.

57. Dr. Agnello-Dimitrijevic's notable impressions were (1) encephalopathy, multifactorial secondary to embolic stroke/sedation, (2) acute right anterior cerebral artery

and middle cerebral artery, ischemic infarcts, (3) mitral regurgitation, status post mitral valve repair, among other observations.

58. Dr. Agnello-Dimitrijevic noted clinically that Mr. Kostadinovski had evidence of not only right hemispheric ischemic stroke, but involvement of the contralateral corticospinal tracts. There was also evidence of not only an aberrant mentation, but bi-lateral Babinski reflexes sustained bilateral ankle clonus and left Hoffmann reflexes.

59. It was noted by Dr. Agnello-Dimitrijevic at the time of this initial consultation that she discussed the findings with the patient's family at length and noted Mr. Kostadinovski's guarded prognosis and ultimate need for extensive rehabilitation.

60. An additional CT of the head and cervical spine, without contrast, and three-dimensional reconstruction with PACS was performed on December 16, 2011, which was compared to the prior examination from December 15th, 2011. The impression of Frank Randazzo, M.D. was acute right-sided water shed and interior cerebral artery infarctions, as before with no significant interval change.

61. On December 17, 2011, a CT of the head, without contrast, was performed and compared with the December 15, 2011 study. The impression was right-cerebral hemispheric stroke with edema and developing areas of encephalomalacia with the ventricular system remaining patent and left anterior cerebral artery distribution infarction, as well.

62. Also noted was concern for brain stem ischemic change and likely remote ischemic change of the right cerebellum and paranasal sinus findings. This was interpreted by Michele Keys, D.O.

63. On December 17th, 2011, the consultation of neurosurgeon Vittorio Morreale, M.D. was requested for the reason of a large infarct with mass affect. Dr. Morreale indicated that Mr. Kostadinovski developed infarct immediately with surgery and has remained intubated since. He further noted that Mr. Kostadinovski is non-verbal and has had dense left hemiplegia since surgery. It was Dr. Morreale's impression that Mr. Kostadinovski did not require intracranial pressure monitoring and that this treatment plan was discussed with Dr. Agnello-Dimitrijevic.

64. There is a rehabilitation consultation note from David K. Davis, M.D later on during Mr. Kostadinovski's hospital stay. Dr. Davis noted that radiology was reviewed that indicated that a head CT showed right cerebral edema with ischemia, anterior, middle and posterior cerebral arteries and subarachnoid hemorrhage was also seen with partial uncal herniation due to edema in the right temporal horn and ischemia right-posterior cerebral artery is also seen. The impression of Dr. Davis was a patient that was status post-acute large stroke, right side of the brain with dense left-sided weakness and left hemineglect and dysphagia, poor trunk control and very low functional level at the time of the consultation which was approximately 13 days from stroke.

65. Also, at the time of Dr. Davis' consultation, it was noted that Mr. Kostadinovski's function status was too low for in-patient rehab, which would signify a much longer time needed for recovery. Dr. Davis also indicated to continue PT and OT, and because his criteria would not meet in-patient rehab admission criteria, Dr. Davis would recommend sub-acute rehab admission at this time until his condition improved.

66. Mr. Kostadinovski remained on ventilator support until he was extubated on December 23rd, 2011 and was eventually transferred to a cardiac step-down unit where he

had an extended hospital stay before ultimately being discharged on January 4, 2012 to Hartford Rehabilitation Center.

67. Mr. Kostadinovski's discharge summary included diagnosis of ventilator dependent respiratory failure, right anterior cerebral artery infarct, for which he was being discharged to Hartford Rehab for further rehabilitation.

68. Mr. Kostadinovski was discharged to Hartford Rehab Clinic with instructions to follow-up with Drs. Harrington, Al-Zagoum and Jafari.

69. Mr. Kostadinovski underwent a pro-longed rehabilitation course and no longer has the ability to perform his ADL's and live a life as he did prior to the date of the surgery. Mr. Kostadinovski has suffered all other damages and injuries as noted throughout this Complaint.

COUNT I: MEDICAL NEGLIGENCE OF STEVEN D. HARRINGTON, M.D.

The Plaintiffs hereby restate, reallege, and incorporate by reference each and every allegation set forth above and further states, in the alternative, the following:

70. At all times pertinent to this Notice, the standard of care applicable to Steven D. Harrington, M.D., required him to maintain the standard of care of his peers within the professional community of cardiothoracic surgeons.

71. The requirements of the standard of care included, but were not limited to, the

a. On December 9. 2011, and continuously thereafter, Dr. Harrington was required to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

b. On December 9, 2011, and continuously thereafter, Dr. Harrington was required to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

c. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington was required to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

d. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington was required to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

e. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

f. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot, thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

g. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to adequately monitor Mr. Harrington's hypotensive status and communicate with Lynn Masinick intraoperatively so as to insure Mr. Kostadinovski received proper perfusion throughout the operation;

h. On December 14, 2011 and continuously thereafter, Dr. Harrington was required to order that Mr. Kostadinovski be transfused when he became hypotensive intra-operatively;

i. Dr. Harrington was required to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

72. Notwithstanding said obligations, and in breach thereof, Defendant Dr. Harrington violated the standard of care applicable in the manner set forth below:

a. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to perform and appreciate a thorough history and physical of Mr. Kostadinovski to insure that Mr. Kostadinovski was a proper surgical candidate for a DaVinci mitral valve repair, as was performed on December 14th, 2011;

b. On December 9, 2011, and continuously thereafter, Dr. Harrington failed to order and review any and all pre-operative diagnostic studies to insure that Mr. Kostadinovski was a proper candidate for the DaVinci mitral valve repair surgery as was performed on December 14, 2011, which would include but not be limited to X-rays, CT scans, CT angiograms and any and all other radiograph diagnostic testing necessary in order to properly assess Mr. Kostadinovski;

c. On December 9, 2011 and December 14, 2011, and continuously thereafter, Dr. Harrington failed to refrain from performing a mitral valve replacement with bypass by use of EndoClamp as described during the December 14, 2011 DaVinci mitral valve repair;

d. On December 9, 2011 and December 14, 2011 and continuously after December 9, 2011, Dr. Harrington failed to evaluate the risk for stenosis and calcification using intra-operative transesophageal echocardiogram and consult all other prior pre-operative studies, including, but not limited to CT studies and CT angiograms to determine whether an EndoClamp was indicated during the DaVinci mitral valve repair as was performed on December 14, 2011;

e. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to immediately abort the DaVinci mitral valve repair due to the presence of thrombus, clot or calcium within the arterial tree;

f. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to use the care and technique of a reasonable surgeon performing the DaVinci mitral valve repair surgery as performed on December 14, 2011 and to avoid disrupting any calcium, clot,

thrombus or other build-up in the arterial tree during the DaVinci mitral valve repair;

g. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to adequately monitor Mr. Harrington's hypotensive status and communicate with Lynn Masinick intraoperatively so as to insure Mr. Kostadinovski received proper perfusion throughout the operation;

h. On December 14, 2011 and continuously thereafter, Dr. Harrington failed to order that Mr. Kostadinovski be transfused when he became hypotensive intra-operatively;

i. Dr. Harrington failed to adhere to any and all additional requirements of the standard of care as may be revealed through the discovery process.

73. Each injury and element of damage noted below was factually and foreseeably caused by the standard of care violations described above by Dr. Harrington.

74. As a direct and proximate result of each breach of the standard of care as outlined above, Drago Kostadinovski suffered and continues to suffer a permanent impairment to his cognitive capacity rendering him incapable of making independent responsible life decisions and permanently incapable of independently performing the activities of normal daily living. As such, Drago Kostadinovski is entitled to the higher noneconomic damage cap pursuant to MCLA 600.1483.

75. As a result of each breach of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer pain and suffering, disability and disfigurement, emotional distress, anxiety, denial of social pleasures and enjoyments, humiliation, medical expenses, loss of earnings, and a loss of earning capacity.

76. As a direct and proximate result each violation of the standard of care outlined above, Drago Kostadinovski suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral

artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain and suffering, loss of ability to perform all activities of daily living, along with all other damages and injuries as noted within this complaint.

77. Had Dr. Harrington followed the standard of care and performed and appreciated a full history and physical, ordered and reviewed all necessary pre-operative radiographic testing and/or studies, including, but not limited to, x-rays, CT studies, CT angiograms, and any and all other necessary radiographic testing, he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and/or cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp as was performed on December 14, 2011. Had Dr. Harrington performed the proper preoperative testing, he would have aborted the procedure and/or would have used a different technique aside from the use of an EndoClamp. Had Dr. Harrington declined to perform this elective mitral valve repair and/or refrained from using the EndoClamp, thrombus, clot or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

78. Had Dr. Harrington followed the standard of care and properly monitored and observed the intraoperative transesophageal echocardiogram (TEE), he would have been able to identify thrombus, clots, or calcium within the arterial tree which would embolize and cause a stroke and/or ischemic infarct when using the technique such as a DaVinci mitral valve repair using an EndoClamp. Had Dr. Harrington observed the

standard of care in this respect, he would have aborted the procedure and/or used a different technique aside from the EndoClamp approach. Had Dr. Harrington declined to perform this elective mitral valve repair at this point and/or refrained from using the EndoClamp, thrombus, clot, or calcification would not have broken loose or formed causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

79. Had Dr. Harrington followed the standard of care and used the care and technique of a reasonable surgeon in performing the DaVinci mitral valve repair surgery, he would have avoided disrupting any calcium, thrombus or other build-up in the arterial tree during the operation and he would have avoided causing the above referenced injuries and damages to Mr. Kostadinovski. Had Dr. Harrington observed the standard of care in this respect, he would have aborted the surgery and/or used a different approach and/or surgical technique while performing the December 14, 2011 DaVinci mitral valve repair surgery. Had Dr. Harrington maintained the standard of care in this respect, thrombus, clot or calcification would not have broken loose or formed, causing stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

80. Had Dr. Harrington adequately monitored Mr. Harrington's hypotensive status and communicate with Lynn Masinick intraoperatively so as to insure Mr. Kostadinovski received proper perfusion throughout the operation and had Dr. Harrington ordered that Mr. Kostadinovski be transfused when he became hypotensive intra-

operatively, Mr. Kostadinovski would not have suffered low perfusion and/or stoke and/or encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, as well as all of the damages and injuries previously noted within this complaint.

81. Mrs. Kostadinovski, as the legal wife of Mr. Kostadinovski, is entitled to loss of consortium damages, which are the direct and proximate result of the damages and injuries described above caused by Dr. Harrington. Mr. Kostadinovski along with his wife, are entitled to damages as are deemed fair and just, including, but not limited to the following: reasonable compensation for the pain and suffering incurred by Mr. Kostadinovski, economic loss, emotional damage, loss of consortium, all medical expenses incurred along with a loss of economic opportunity and all other damages and injuries listed previously within this complaint.

82. Had Dr. Harrington followed the standard of care in all respects as outlined above, Mr. Kostadinovski would not have suffered and continues to suffer encephalopathy, ventilator-dependent respiratory failure, right anterior cerebral artery and middle cerebral artery ischemic infarcts, newly onset seizure disorder, a pro-longed hospital stay, pain-suffering, loss of ability to perform all activities of daily living, as well as all damages and injuries previously noted within this complaint.

WHEREFORE, Plaintiffs respectfully request that this Honorable Court enter judgment against the Defendants in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the Plaintiff is deemed to be entitled.

COUNT II: VICARIOUS LIABILITY OF ADVANCED CARDIOTHORACIC SURGEONS, P.L.L.C.

The plaintiffs hereby restate, reallege, and incorporate by reference each and every allegation set forth above and further states, in the alternative, the following:

83. At all times pertinent to this Complaint, Dr. Steven D. Harrington, M.D., was an agent, ostensible agent, servant and/or employee of Advanced Cardiothoracic Surgeons, PLLC. As such, Advanced Cardiothoracic Surgeons, PLLC are vicariously liable for the negligent acts and/or omissions of Dr. Harrington as more fully described above, as well as the injuries and damages flowing from said acts and/or omissions.

WHEREFORE, plaintiffs respectfully request that this Honorable Court enter judgment against the defendants, jointly and severally, and in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the plaintiff is deemed to be entitled.

COUNT III: LOSS OF CONSORTIUM

The plaintiffs hereby restate, re-allege and incorporate by reference each and every allegation set forth above and further state, in the alternative, the following:

84. At all times pertinent to this Complaint, Blaga Kostadinovski was the lawfully wedded wife of Drago Kostadinovski.

85. As a direct and proximate result of the injuries and damages experienced by Drago Kostadinovski, Blaga Kostadinovski, has suffered the loss of her husband's consortium, society, and companionship; emotional distress and anxiety, past, present, and future; and denial of social pleasures and enjoyments, past, present, and future.

WHEREFORE, plaintiffs respectfully request that this Honorable Court enter judgment against the defendants, jointly and severally, and in any amount in excess of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS, together with interest, costs and attorney fees, to which the plaintiff is deemed to be entitled.

RESPECTFULLY SUBMITTED,

MORGAN & MEYERS, PLC

BY _____

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DATED: March 21, 2016

EXHIBIT 9

2016 WL 3004566
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UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

Robert HUNTER, Plaintiff–Appellant,
v.
John M. CILLUFFO, M.D. and John M. Cilluffo M.D., P.L.C., Defendant–Appellee.

Docket No. 326088.
|
May 24, 2016.

Grand Traverse Circuit Court; LC No.2014–030474–NH; 2014–030722–NH.

Before: BOONSTRA, P.J., and WILDER and METER, JJ.

Opinion

PER CURIAM.

***1** Plaintiff Robert Hunter appeals as of right from two orders. Plaintiff appeals the trial court's order granting defendant John M. Cilluffo's (defendant Cilluffo's) motion for summary disposition pursuant to MCR 2.116(C)(7) (claim barred as a matter of law) and MCR 2.116(C)(8) (failure to state a claim on which relief can be granted) in case number 2014–030474–NH (Case I). Case I alleged medical malpractice relating to defendant Cilluffo's conduct "before, during and after" the February 17, 2012, surgery he performed on plaintiff. While Case I was pending, plaintiff filed a separate action against defendant Cilluffo and defendant John M. Cilluffo, M.D., P.L.C. (defendant Corporation), under case number 2014–030722–NH (Case II). Case II alleged medical malpractice specifically during plaintiff's June 28, 2012, surgical follow-up appointment. In light of its ruling in Case I, the trial court entered an order dismissing plaintiff's Case II complaint with prejudice. We affirm.

I. FACTS

Plaintiff alleged that defendant Cilluffo began treating him in either 2005 or 2006 for "ongoing back problems" and performed three surgeries, the last of which occurred on February 17, 2012. Plaintiff described the February 17, 2012, surgery as a "surgery to address ... disc herniations" in his "low back area" that required "decompression and fusion procedures," and then went on to describe specific areas of his back where defendant Cilluffo decided to operate and specific areas where defendant Cilluffo chose not to operate. After the surgery, plaintiff alleged, he experienced pain and continued to see defendant Cilluffo until June 28, 2012.

Because of the pain and injuries plaintiff allegedly sustained during and following the February 17, 2012, surgery, plaintiff filed a notice of intent (NOI) to file suit against defendant Cilluffo and "John M. Cilluffo, M.D., P.C.," dated February 17, 2014. [1] The NOI stated that "[i]mmediately following the [February 17, 2012,] surgery, [plaintiff began] complaining about severe pain and [a] limited range of motion in his low back area[,] began having trouble standing up straight during the early days of his post-surgical recovery[, and] felt a hard object protruding from his low back area...." The NOI explained that plaintiff "voiced his post-operative complications to [defendant] Cilluffo," but defendant Cilluffo "ignored" plaintiff's concerns and "refused to even palpate the area...."

1 The action against "John M. Cilluffo, M.D., P.C." was dismissed, as the entity no longer existed.

The NOI went on to explain that plaintiff "had several post-operative visits with [defendant] Cilluffo during which [plaintiff] continued to voice the same complaints," but "[a]gain, [defendant] Cilluffo ignored those complaints." The NOI stated that defendant Cilluffo sent plaintiff "for conditioning therapy" in "late April 2012," but the "physical therapy staff ... decided that [plaintiff] should not be treated until further diagnostic studies were performed" and "contact[ed defendant] Cilluffo regarding the need for further diagnostic studies...." This request, the NOI alleged, "may be why [defendant] Cilluffo ordered a MRI study of the lumbar spine with and without contrast material and a CT study of the lumbar spine without contrast."

***2** The NOI explained that two other doctors reviewed the MRI and CT studies; the MRI was reviewed on June

22, 2012, and the CT was reviewed on June 23, 2012. The NOI stated that reports concerning the MRI and CT tests "mentioned a kyphotic deformity above the February 17th fusion site" and further stated that the tests "likely" made "the area immediately above the L–1 vertebrae ... visible." According to the NOI, despite these results, defendant "Cilluffo chose ... to highlight the seemingly larger disc herniation at the T12–L1 level as a likely cause for [plaintiff]'s ongoing back pain and inability to stand erect." Accordingly, defendant "Cilluffo suggested that [plaintiff] undergo still another surgical procedure to address that expanding herniation, which [defendant] Cilluffo had chosen to ignore during the February 17th surgery...." The NOI explained that plaintiff "refused," and his treatment with defendant Cilluffo ended in "late June 2012...."

After plaintiff stopped his treatment with defendant Cilluffo, the NOI alleged, he saw other doctors who identified problems with defendant Cilluffo's surgery and with plaintiff's back. Another doctor performed back surgery on plaintiff that allegedly involved "remov[ing] all of the hardware placed by [defendant] Cilluffo" in prior surgeries.

The NOI then explained that the "standards of care for neurosurgeons required the sagittal balance be carefully considered before, during and after any fusion procedure involving the lower back when the patient has had two prior fusion procedures of the spine," "that any evidence of possible loosening of the fusion hardware ... be thoroughly investigated and corrected surgically, if necessary, on an urgent basis if it was determined that the fusion was in jeopardy due to the loosely fitting hardware," and that the "maintenance of a good sagittal balance in the spine was particularly important...." The NOI alleged that defendant Cilluffo breached that standard of care

> when he failed to consider the possibility that he might be creating a sagittal imbalance in [plaintiff]'s spine before, during and after the February 17th procedure[,] ... failed to address [plaintiff]'s complaints regarding his inability to stand erect and [plaintiff's] complaints of ongoing pain in a timely manner[, and] failed to even examine [plaintiff]'s low back area regarding [plaintiff]'s claims that there were hard objects protruding from under his skin.

In contrast, the NOI alleged, defendant Cilluffo

> would have complied with the applicable standards of care if he had considered ... that [plaintiff]'s third spinal fusion might create [several problems; taken steps during the surgery to correct those problems;] ... respond[ed] to [plaintiff]s's complaints regarding severe pain in the back following surgery, an inability to stand erect, and his complaints that he could feel hard material bulging from under his skin the repaired area[; and] surgically correct[ed] the obvious defects in a timely manner....

***3** Instead, "[a]s a direct and proximate result of the ... negligent acts and omissions," the NOI alleged, plaintiff suffered numerous injuries.

Plaintiff filed his complaint in Case I on August 18, 2014, without an affidavit of merit against defendant Cilluffo and "John M. Cilluffo, M.D., P.C." The Case I complaint alleged that defendant Cilluffo had a "duty to provide medical/surgical care that was consistent with the applicable standards of care for specialists in neurological surgery," requiring that the "sagittal balance be carefully considered before, during and after any fusion procedure involving the lower back when [plaintiff] has had two prior fusion procedures of the spine," and that "any evidence of possible loosening of the fusion hardware had to be thoroughly investigated and corrected surgically, if necessary, on an urgent basis if it was determined that the fusion was in jeopardy due to the loosely fitting hardware." It further alleged that defendant Cilluffo breached that duty when he "failed to consider the possibility that he might be creating a sagittal imbalance in Plaintiffs spine before, during and after the February 17th procedure," "failed to address Plaintiff's complaints regarding his inability to stand erect and his complaints of ongoing pain in a timely manner," "failed to even examine Plaintiffs low back area regarding [his] claims that there were hard objects protruding from under his skin," and

"failed to perform remedial surgery to correct the defects in a timely manner...."

Plaintiff informed the trial court that he had offered to stipulate to a dismissal of Case I without prejudice because he failed to file an affidavit of merit within the time permitted in MCL 600.2912d(3) and that he was considering another action due to the defense's failure to respond to radiological studies performed on June 22, 2012, and June 23, 2012, that defendant Cilluffo reviewed on June 28, 2012. Plaintiff believed that his earlier-filed NOI covered such a claim, which would toll the statute of limitations for 182 days. Instead of agreeing to the dismissal, defendant Cilluffo filed a motion for summary disposition pursuant to MCR 2.116(C)(7) and (C)(8), requesting that all of plaintiff's claims be dismissed with prejudice. Significantly, he argued that the NOI did not cover such an action because it never mentioned June 28, 2012.

Before responding, plaintiff, on December 30, 2014, filed his Case II complaint without an affidavit of merit against defendants. The Case II complaint alleged that "Defendants were served with [NOIs] pursuant to MCL 600.2912b(1)(4)...." Significantly, plaintiff alleged that he "continued to see Defendants until sometime in June 28, 2012[sic]." Plaintiff alleged that defendant Cilluffo's duty of care required him, "when confronted with any significant evidence of loosening of the fusion hardware or a non-union of the fusion, [to] proceed surgically on an urgent basis to address those conditions," but that defendant Cilluffo breached that duty "when he failed to timely address Plaintiff's complaints regarding an inability to stand erect, hard objects projecting outward from his spinal area, and complaints of ongoing pain ... despite having actually reviewed the MRI and CT imaging studies obtained on June 22, 2012 and June 23, 2012 respectively, which demonstrated" injury, and in "fail[ing] to perform remedial surgery to correct the apparent defects in a timely manner...."

***4** In responding to the defense motion for summary disposition, plaintiff argued that the NOI addressed defendants' June 28, 2012, actions. Therefore, he asserted, the NOI tolled the statute of limitations, allowing for a dismissal of Case I *without* prejudice and the filing of Case II. The trial court disagreed and granted the defense motion for summary disposition in Case I with prejudice, finding that the NOI contained "very little mention of these two [June 22, 2012, and June 23, 2013,] studies," and that plaintiff's "claim of malpractice against [defendant] Cilluffo is [that] he failed to read [the studies] properly or misinterpreted them," but "[n]owhere in the [NOI] does it say that that's the standard of care [defendant Cilluffo]'s supposed to have breached." Therefore, the court concluded, the NOI was not "sufficient to toll the statute of limitations with respect to the act of malpractice on June 28, [2012,] and[, thus,] the [limitations period] actually expired June 28, 2014." Plaintiff "agree[d] in light of the ruling [that] both [cases] would be dismissed with prejudice," so the trial court also dismissed plaintiff's Case II complaint with prejudice. This appeal followed.

II. ANALYSIS

Plaintiff argues that his NOI fully complied with MCL 600.2912b(4) with regard to defendant Cilluffo's failure to properly review the imaging studies he had in his possession during plaintiff's June 28, 2012, clinical visit and defendants' corresponding failure to provide proper care on June 28, 2012. We disagree.

We review de novo a trial court's decision regarding a motion for summary disposition. *Roberts v. Mecosta Co. Hosp.,* 470 Mich. 679, 685; 684 NW2d 711 (2004). We also review de novo issues involving the proper application of a statute. *Ligons v. Crittenton Hosp.,* 285 Mich.App 337, 342–343; 776 NW2d 361 (2009).

Before commencing a medical malpractice action, a plaintiff must give the potential defendant "health professional[s]" or "health facilit[ies]" at least 182 days' written notice of the action. MCL 600.2912b(1). Doing so tolls the two-year limitations period, MCL 600.5805(6), for the 182–day notice period, *Roberts,* 470 Mich. at 685–686. The written notice must contain a statement of at least all of the following:

(a) The factual basis for the claim.

(b) The applicable standard of practice or care alleged by the claimant.

(c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.

(d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.

(e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.

(f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim. [MCL 600.2912b(4).]

***5** Plaintiff bears the burden of establishing all six requirements. *Roberts,* 470 Mich. at 691.

In determining what is required to comply with MCL 600.2912b(4), the Court in *Roberts,* 470 Mich. at 701, concluded that the NOI must contain a "degree of specificity which will put the potential defendants on notice as to the nature of the claim against them." The NOI must specify the allegations against each individual defendant, *id.* at 682, but "because the NOI comes at an early stage of the malpractice proceeding, the plaintiff does not have to draft the notice 'with omniscience.' " *Decker v. Rochowiak,* 287 Mich.App 666, 676; 791 NW2d 507 (2010), quoting *Roberts,* 470 Mich. at 691. "Rather, the plaintiff must 'make good-faith averments that provide details that are *responsive* to the information sought by the statute and that are as *particularized* as is consistent with the early notice stage of the proceedings.' " *Decker,* 287 Mich.App at 676, quoting *Roberts,* 470 Mich. at 701 (emphasis in *Roberts*). Doing so "is not an onerous task: all the [plaintiff] must do is specify what it is that [he or] she is *claiming* under each of the enumerated categories...." *Roberts,* 470 Mich. at 701 (emphasis in original). However, information that allows only an inference to be drawn regarding the basis for a statutory ground is insufficient. See *id.* at 697. Similarly, an NOI that merely informs a potential defendant "of the nature and gravamen of plaintiff's allegations" is insufficient. *Boodt v. Borgess Med. Ctr.,* 481 Mich. 558, 560–561; 751 NW2d 44 (2008). Therefore, the plaintiff must go beyond the substantial point or essence of a claim, and, instead, the required information for each category must "be specifically identified in an ascertainable manner...." See *Roberts,* 470 Mich. at 701. No particular "method or format" is required to do so. *Id.*

In this case, defendants do not challenge whether plaintiff's NOI set forth the information required under MCL 600.2912b(4)(f). We address plaintiff's compliance with the remaining subsections with regard to defendant Cilluffo first. [2]

2 Plaintiff's argument that defendant Cilluffo acknowledged notice of claims of alleged negligence on June 28, 2012, in a previous motion for summary disposition is unpersuasive, and plaintiff cites no authority to support his argument that we should consider defendant's actions following an NOI, instead of the NOI's text, in assessing compliance with MCL 600.2912b(4).

While the remainder of plaintiff's NOI may allow an inference to be drawn that he alleged malpractice on June 28, 2012, *Roberts,* 470 Mich. at 697, or may assert the "gravamen" or substantial point or essence of plaintiff's claims, *Boodt,* 481 Mich. at 560–561, such assertions are insufficient to comply with the remaining subsections of MCL 600.2912b(4). It is unclear what exactly plaintiff is "*claiming* " under the remaining subsections with regard to any actions by defendant Cilluffo on June 28, 2012, and the NOI failed to "specifically identif[y]" the factual basis for such a claim. *Roberts,* 470 Mich. at 701. Therefore, plaintiff's NOI was deficient.

With regard to whether plaintiff's NOI "contain[ed] a statement of ... [t]he factual basis of the claim" against defendant Cilluffo, MCL 600.1912b(4)(a), the NOI failed to allege specific acts of malpractice on June 28, 2012. In fact, the parties agree that the NOI never mentioned the date June 28, 2012. Instead, plaintiff's NOI stated that plaintiff began "complaining about severe pain and [a] limited range of motion in his low back area[, plaintiff] began having trouble standing up straight during the early days of his post-surgical recovery[, and] felt a hard object protruding from his low back area" "[i]mmediately following the [February 17, 2012,] surgery." The NOI further explained that plaintiff "voiced his post-operative complications to [defendant] Cilluffo" during "several post-operative visits...." However, plaintiff never tied these complaints to any particular date or office visit. Cf. *Ligons,* 285 Mich.App at 341, 344–345. The NOI claimed that defendant "Cilluffo ordered a MRI study of the lumbar spine with and without contrast material and a CT study of the lumbar spine without contrast," claimed that the images "mentioned a kyphotic deformity," and described how other doctors reviewed these images. The

NOI appears to suggest that defendant Cilluffo reviewed these images, focused on an alternative back problem, and recommended a surgery that plaintiff rejected. However, the NOI never clearly stated that defendant Cilluffo reviewed the MRI or CT scans, clarified how his review, or lack thereof, constituted malpractice, or tied this review and any subsequent recommendation to a June 28, 2012, office visit. Therefore, the NOI failed to comply with MCL 600.2912b(4)(a).

***6** "Proof of the standard of care is required in every medical malpractice lawsuit...." *Roberts,* 470 Mich. at 694 n. 11. With regard to whether the NOI included "a statement of ... [t]he applicable standard of ... care," MCL 600.2912b(4)(b), the NOI again failed to "specifically identif[y]" the standard of care that defendant was required to follow during the June 28, 2012, appointment, *Roberts,* 470 Mich. at 701. The NOI stated that "standards of care for neurosurgeons required the sagittal balance be carefully considered before, during and after any fusion procedure involving the lower back when the patient has had two prior fusion procedures of the spine," "that any evidence of possible loosening of the fusion hardware ... be thoroughly investigated and corrected surgically, if necessary, on an urgent basis if it was determined that the fusion was in jeopardy due to the loosely fitting hardware," and that the "maintenance of a good sagittal balance in the spine was particularly important." When considered in the context of plaintiff's allegations in Case II that defendant Cilluffo was required to perform certain tasks when reviewing the MRI and CT scans conducted on June 22, 2012, and June 23, 2012, and was required to act during a June 28, 2012, appointment, these standards are analogous to the inappropriately general standards alleged in *Roberts, id.* at 694, that defendants must "properly care for [the plaintiff] ... and ... render competent advice and assistance." Therefore, the NOI failed to comply with MCL 600.2912b(4)(b).

With regard to how the NOI phrased the "manner in which it is claimed that the applicable standard of ... care was breached by" defendant Cilluffo, MCL 600.2912b(4)(c), plaintiff's NOI claimed "that [defendant] Cilluffo breached the applicable standards of care when he failed to consider the possibility that he might be creating a sagittal imbalance in [plaintiff]'s spine before, during and after the February 17th procedure[, and] ... failed to address [plaintiff's post-surgery] complaints." Such information references unfortunate circumstances that occurred to plaintiff post-surgery, *Roberts,* 470 Mich. at 697, and may allow an inference to be drawn that plaintiff alleged a breach on June 28, 2012, *id.,* or may assert the "gravamen" of plaintiff's claims, *Boodt,* 481 Mich. at 560–561, but such assertions are insufficient to establish the manner in which defendant Cilluffo breached a required standard of care on June 28, 2012. For example, the NOI failed to reference defendant Cilluffo's use of the CT and MRI studies to facilitate his recommendations. See *Roberts,* 470 Mich. at 697 (finding the statement of breach inadequate because "[t]here [wa]s no allegation, for example, that any of the defendants failed to perform critical tests, incorrectly diagnosed her condition, or failed to refer her to a specialist in keeping with the appropriate standard of care). Therefore, the NOI failed to comply with MCL 600 .2912b(4)(c).

***7** With respect to whether the NOI "contain[ed] a statement of ... [t]he alleged action that should have been taken to achieve compliance with the alleged standard of practice or care," MCL 600.2912b(4)(d), plaintiff's NOI stated that defendant Cilluffo should have "considered ... that [plaintiff]'s third spinal fusion might create" several problems, taken steps during the surgery to correct those problems, "respond[ed] to [plaintiff]'s complaints," and "surgically correct[ed] the obvious defects in a timely manner...." However, the NOI "failed to identify any particular action that defendant [Cilluffo] should have taken to achieve compliance with the standard of care" on June 28, 2012. *Roberts,* 470 Mich. at 698 (emphasis removed). Therefore, defendant Cilluffo was inappropriately "left to guess ... which aspect of plaintiff's treatment was deficient" on June 28, 2012, and left to guess "what plaintiff alleges defendant[Cilluffo] should have done differently." *Id.;* cf. *Ligons,* 285 Mich.App at 345. Thus, the NOI failed to comply with MCL 600.2912b(4)(d).

Finally, this Court must consider whether the NOI "contain[ed] a statement of ... [t]he manner in which it is alleged the breach of the standard of ... care was the proximate cause of the injury claimed." MCL 600.2912b(4)(e). Plaintiff's NOI no doubt described numerous injuries that he sustained, but he claimed that those injuries were caused "[a]s a direct and proximate result of the ... negligent acts and omissions" described in the NOI. Because the NOI insufficiently described the alleged negligence of defendant Cilluffo on June 28, 2012, such a statement was insufficient to tie plaintiff's injuries

to defendant Cilluffo's conduct on that date. Therefore, the NOI failed to comply with MCL 600.2912b(4)(e) and plaintiff's NOI was deficient.

Plaintiff did not argue that the statute of limitations should be tolled in light of the NOI's deficiencies, *Bush v. Shabahang,* 484 Mich. 156, 170; 772 NW2d 272 (2009), request an opportunity to amend his NOI in lieu of dismissal, or argue that an amendment would be "in the furtherance of justice," *id.* at 176–177. Therefore, we uphold dismissal of plaintiff's claims against defendant Cilluffo.

We now turn to evaluating the NOI's claims against defendant Corporation, given that NOIs must set forth allegations as "applicable to each named defendant," including specific allegations against professional corporations in addition to the doctors they employ. *Roberts,* 470 Mich. at 682, 692–694. Defendant Corporation was not a party to the action in which defendant Cilluffo filed the motion for summary disposition. Plaintiff listed "John M. Cilluffo, M.D., *P.C.*" in his NOI. (Emphasis added.) Defendant Corporation was added in Case II. Therefore, the NOI was deficient with regard to defendant Corporation, MCL 600.2912b(4), and plaintiff failed to give defendant Corporation at least 182 days written notice before filing his Case II complaint, MCL 600.2912b(1).

***8** "Because a medical malpractice plaintiff must provide *every* defendant a timely NOI in order to toll the limitations period applicable to the recipient of the NOI, plaintiff failed to toll the limitations period...." *Driver v. Naini,* 490 Mich. 239, 251; 802 NW2d 311 (2011) (emphasis in original). Plaintiff's Case II complaint against defendant Corporation was time-barred, MCL 600.5805(6), and, thus, the trial court appropriately dismissed plaintiff's claim against defendant Corporation.

Affirmed.

All Citations

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